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Women:

Their Use of Alcohol and Other Legal Drugs

Women: Their Use of Alcohol and Other Legal Drugs

A PROVINCIAL CONSULTATION - 1976

Edited by Anne MacLennan

compiled by Lavada Pinder

ADDICTION RESEARCH FOUNDATION OF ONTARIO

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Introduction

The first Provincial Consultation on women and addictions in Ontario, and in Canada, was held in Ottawa on September 29th and 30th, and October 1st, 1975.

The immediate aim was to bring together a small group of concerned, knowledgeable people for two-and-a-half days of intensive discussion about women and their use of alcohol and other legal drugs. The ultimate aim was to contribute further to the understanding of, and to generate interest in, this still neglected area.

Meetings in this field of addictions are almost countless. But, for a meeting to focus solely on women has been unusual in the extreme.

Addictions has been largely a man's world. This is perhaps particularly so with regard to alcoholism: Researchers, program-designers, and policy-makers are usually men. That alcoholism has been seen as a male disorder may be the cause of that predominance of men in the field, or it may be the effect.

For whatever reasons, however, those who dominate addictions research and treatment tend to be men. And the overwhelming majority of their professional effort has been directed at other men.

Mindful of this ingrained tradition, and with no apologies, the organizers of the Consultation allowed for, indeed planned for, a bias in favor of women.

The 27 participants from across Ontario were women. Their commitment to this focus had been sought prior to the Consultation in invitations which made three things clear: The Consultation would be about women; about the special problems of women in relation to alcohol and legal drugs; and about the societal context in which these problems exist.

To support and strengthen this focus, five women were invited to prepare working papers which would act as catalysts for informed discussion and were required pre-Consultation reading.

While the papers are by women in five different areas of work, they all demonstrate a basic concern for women.

Two deal exclusively with women in society. In *The Changing Role of Women*, Sandy Stienecker analyses the current status of women and outlines obstacles she believes limit women's full participation in society.

In her paper, *On Women and on One Woman*, Helen Levine speaks personally as both a provider and consumer of services, and illustrates, often poignantly, the inadequacies of our health and social care system.

Three of the papers focus directly on women and their use of legal drugs.

Patricia Badiet, in an extensive review of the literature, makes it clear research on women and alcoholism in Canada is sorely neglected and points to several areas which warrant early study.

In her paper, Winnie Fraser discusses her experience as acting head of the only detoxication unit in Southern Ontario which has beds for women as well as men.

Ruth Cooperstock has studied consumption of legal drugs in Ontario for 10 years. Her paper, *Women and Psychotropic Drugs*, has significant implications for prevention and treatment policies, and provides a data base on legal drugs in Ontario which cannot be matched by any available information on alcohol.

These five papers, together with the knowledge and experience of the participants, were the raw material for the two-and-a-half days of discussions which were demanding and often provocative, but never boring, and which culminated in the formulating of a series of recommendations for improvements.

The purpose of this publication is to bring to those of you who were not at the meeting, some of the "raw material".

It is also our hope that it will generate in you some of the excitement, anger, and commitment that those of us who were there experienced.

Lavada Pinder
Director
Ottawa-Carleton Programs
Addiction Research Foundation of Ontario

Acknowledgements

The Consultation on Women could not have been held and this book not published without:

The Non-Medical Use of Drugs Directorate (Non-MUD) which financed the meeting;

Patricia Badiet whose review of the literature on women's use of alcohol and other legal drugs triggered the idea;

Lavada Pinder who was determined that a Consultation should be held and who was chief organizer;

Rita Lucht and Jessica Hill of Non-MUD who enthusiastically supported the concept and worked tirelessly in the organizing;

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The Changing Role of Women

by Sandy Stienecker

The role of women creates in women many of the characteristics commonly attributed to drug and alcohol dependents. It is an inferior and limited role. Despite a change in the popular rhetoric about the role of women, the role itself remains unchanged. It remains so because of the definition of and restrictions placed on women by the existing economic and social structure which must continue to exploit women.

The effect of publicity about new opportunities for women, juxtaposed with the reality of an unyielding structure, has confounded and confused women's role in this society.

Because they are now told a liberated woman is a possibility, all women must confront what seems a personal failure if they don't achieve this liberation. But, it is an impossible attainment given that the structures and institutions which block their growth and development remain unchanged.

Betty Friedan realized more than 10 years ago that North American culture "does not permit women to accept or gratify their basic need to grow and fulfill their potentialities as human beings". (1)

Ms Stienecker is a community organizer with the YWCA, Toronto.

The position of women in this society reflects the cultural and political requirements that women must be defined in terms of their childbearing capacity and their relationship to men.

In the last analysis, women are defined always on the basis of their relationship to others, i.e. their children, their husbands, their friends, their employers. They are expected to receive their status vicariously through the achievements of these others. Never are women defined on the basis of the development of their own skills and achievements.

> *"This is the substance of sexism. This is the creation of thousands of years of thought and reinforced patterns of behavior, so deeply imprinted, so utterly subscribed to by the great body of Western conviction, that they are taken for 'natural' or instinctive. Sexism has made of women, a race of children, a class of human beings utterly deprived of selfhood, of autonomy, of confidence--worst of all it has made the false come true. Women have so long shared acquiescently in society's patriarchal definition of them as beings composed of warmth, passivity, nurturance, inert egos, and developed intuition, that they have become the very thing itself, and can no more see themselves in that mirror of life that declares independence, aggression, intellectual abstraction, and primary responsibility to be the silhouette of human development, than can men. As a result, women have long suffered from an image of the self that paralyzes the will and short circuits the brain, that makes them deny the evidence of their selves and internalize self doubt to a fearful degree... Should they reveal strong wishes that their lives form themselves around an altogether other definition, they are branded unnatural." (2)*

How do women become this way? It begins with the socialization process which programs and educates women to their limited and inferior role. This process defines women as dependent, passive, fragile, having low pain tolerance,

non-competitive, inner-oriented, empathetic, sensitive, nurturant, yielding, intuitive, receptive, unable to risk, and supportive. Men are defined as independent, aggressive, competitive, leaders, task-oriented, assertive, innovative, self-disciplined, stoic, active, objective, analytic, courageous, unsentimental, rational, confident. (3)

The kinds of toys children are given, the stories they hear and read, the roles their parents play, and the responses they receive to particular behavior, are all part of socialization.

Generally, the childhood behavior of females receives more approval from adults than the childhood behavior of males. More highly developed perceptual, cognitive, and verbal skills are characteristic in girls and enable them to interpret, anticipate, and conform to adult expectations. Because young boys do not usually have these skills developed to such a high degree, and because dependent behavior is discouraged in boys, they are forced to seek affirmation of themselves from new, less stable sources. Boys then begin to develop a sense of self, and criteria of worth, which are relatively independent of others' responses. (4) This is not the case for girls.

By the time a girl has reached school age, she is already predisposed to accept her life pattern. When it is suggested she become a nurse, rather than a doctor, she doesn't question the validity of the suggestion.

The school system rewards passivity and conformity. Because girls have learned to depend on others for self-definition and affirmation and are adept at anticipating other people's demands, they conform easily. They do well in grammar, spelling, reading, arithmetic—tasks that depend a great deal upon memorization and require little independence, assertiveness, analysis, innovation, or creativity. (5) By high school, they have not developed these kinds of skills and are weak in subjects where they are required.

In her study, done in 1966, Eleanor Macoby showed there are no significant intellectual differences until high school, and then women clearly start becoming inferior. (6)

Naomi Weinstein suggests: "In light of social expectations about women, what is even more remarkable is that some women resist this message even after high school,

college, and graduate school." (7)

The courses women choose (usually with professional "guidance") in high school, have already narrowed their choices and chances for further education. The number of girls taking commercial courses is substantially higher than the number of boys. (8) In the academic courses, boys tend to study mathematics and science, while girls lean to social studies. (9)

In addition to the psychological barriers set up by early socialization, girls' educations are also limited by financial circumstances.

According to the Royal Commission Report on the Status of Women, female students are more dependent on their parents for financial support. (10) In most families, if finances make it necessary to choose between further education for a girl and a boy, the boy is given preference. If a woman persists in seeking an education, she will find while there is "no substantial difference between the essential expenses of men and women students", men receive proportionately higher aggregate stipends. (11) Men also earn more money during summer employment than women. (12)

Many briefs presented to the Royal Commission on the Status of Women show that universities still discriminate against women by imposing quotas on the number of women allowed into certain faculties or by requiring women to have a higher academic standard than men.

If the educational system defines girls as inferior, the business world reinforces that process. Advertising echoes the stereotypes created in schools, textbooks, and relationships.

While men, as well as women, suffer from stereotyping, advertising encourages in women qualities such as dependence, passivity, vicarious achievement, and, above all, acceptance and approval by others. Coincidentally, these are the precise qualities that make better consumers. Women are portrayed in advertisements as housewives or femme fatales who think only of their appearance or their household. They conform strictly to the beauty standards men have set for them. More than 89% of the women

pictured in Canadian newspapers are under 35 years of age. (13) Since less than 89% of the adult population are in fact under 35 years of age, conforming to those youthful beauty standards is a problem. Women listen very carefully to the messages. Anxiety about appearing "older" impels them to purchase wrinkle cream and hair coloring--not to satisfy their vanity but in an effort to maintain, or gain, acceptability in a society that validates only the youthful.

There is now some questioning of, and objection to, the stereotyping of women, and some encouragement for rejecting the traditional patterns. Women are beginning to hear they are "free" to choose careers, remain single, dress and look as they please. But to expect them to choose these "options" is to expect them to overcome years of socialization and cultural conditioning.

The women who have dared, individually, to make these small changes have met with suspicion, anger, and isolation. Those who have resisted their socialization, tried to define themselves in their own terms, and survived the hostility, are rewarded with the realization that real opportunities for full development do not exist. Women are socialized the way they are so they will fit into the social system. And the system will not change merely because women object to the socialization process.

And this is the real problem. Women face very real obstacles in every area of life specifically, but not always obviously, in relation to the law, the work force, and the health and social services.

The law serves to limit women's participation in this society. Women's dependence on men is clearly enforced by the marriage and divorce laws. The double standard is enshrined in the marriage laws which require the woman to be sexually available and faithful to her husband or lose her "claim" to support. Canadian law restricts the mobility of wives who must remain with their husbands or risk being charged with desertion. This same law does not apply to men. The verdict of the Supreme Court in the Murdock case in Alberta awakened many Canadian women to the compensation they can expect on the dissolution of a marriage. Canada's family property law puts the woman who has worked in her home throughout her marriage into the role of

unpaid slave. These laws force women to remain in bad marriages. Often the only option is welfare.

The abortion clauses in Canada's Criminal Code were amended in 1969 to enable doctors to perform therapeutic abortions under certain conditions. These laws, however, do not allow women free choice. They require them to convince doctors (usually men) that they should be allowed an abortion.

"The major benefit of the change appears to be that doctors who do abortions according to the rules are not liable for arrest.... Women, especially the poor, the very young, those living in small communities, and those served by hospitals that disapprove of abortion, are hardly affected." (14) Thus, thousands of women each year are forced to seek illegal and unsafe abortions.

It becomes apparent that adequate birth control information, safe and effective birth control techniques, and easily accessible clinics are the necessary first steps towards reducing the number of abortions. (15)

While laws regarding marriage and abortion have gained public attention through the work of the women's movement, many other areas of law affect the lives of women. Criminal law seriously discriminates against women in the "letter of the law" and in its application, as well as in the administration of so-called treatment centres and penitentiaries.

While all laws effectively control women's sexuality, nowhere is this more evident than in the laws pertaining to rape. Rape is a societal crime as well as an individual crime, arising from (and in fact sanctioned by) society's definition of women as sexual property. The very peculiar legal requirement that the *victim* prove her integrity and that there be corroboration, in addition to the extremely narrow definition of rape, all suggest strongly that protection and justice for the victim are not the law's primary concerns. (17)

Even more serious, is the situation of women in terms of the work force. Women continue to be exploited, and the government has failed to enact legislation which guarantees adequate and universal minimum wages and enforces the principle of equal pay for work of equal value. Low pay and

few job opportunities limit women's role in this society. In 1971, some 2,831,000 women working outside the home comprised 32.8% of the labor force. They represented 36.5% of the female population aged 14 or beyond, and 33% of all married women. More than half of all employed women were concentrated in just two occupational groups—clerical, and service and recreation. Yet, although the number of women in the labor force has increased significantly, this occupational distribution has not changed. The jobs which most women hold are considered "female" jobs—72% of all clerical workers are women, 60% of all service and recreation workers are women.

In 1961 in Canada, the average wage for fulltime male workers was $4,446, as compared to $2,620 for fulltime female workers or 59% of men's earnings. In 1967, the average annual income was $5,331 for men but for women it was $2,303, or 43% of the male average. The Department of Labour of Ontario attributes women's lower incomes to the fact women are concentrated in low-status, low-paying jobs. (18)

Many of these working women need daycare for their children. In 1970, 58% of all employed women in Canada were married (the figure is higher in Ontario). (19) In 1966, 82% of the 125,000 single parent families in Ontario were headed by women. The number of single parent families had increased to 338,000 by 1971. (20) In Ontario in 1970, there were 135,000 children under the age of six whose mothers worked; at the same time, there were fewer than 10,000 places in full daycare, private and municipal. (21) In Canada in 1973, there were 1,537,000 children of working mothers; at the same time there were 26,811 children of working mothers in fulltime daycare and latch-key programs, i.e. 1 3/4% of the total have daycare. (22)

It is important to note these are government estimates of the need for daycare and they consider only the needs of mothers already in the work force. They ignore entirely the needs of women at home. In addition to the important educational experience daycare provides for children, there is also a need for women to have some time away from their children, and our society refuses to recognize this. Government figures on daycare needs do not even consider the women who, if quality daycare were available, would enter

the labor force, continue their education, or take job retraining.

Even those daycare spaces that are available are inaccessible to many because of the costs. While these vary, it is estimated that in Ontario, daycare costs average between $1,500 and $2,600 per annum plus transportation. Since most families earn less than $10,000 per year, this cost is prohibitive. The subsidies that may be available do not apply to median income families. Daycare, therefore, is available only to parents with above average incomes or those who can *prove* they are needy. Generally, welfare recipients are not allowed daycare.

"With the increasing numbers of women in the labor force, informal local arrangements seem less feasible. Women who wish to take advantage of the $500 income tax deduction often are inhibited from using these casual arrangements. Of course the general reliance on informal and haphazard means of meeting needs also results in women working for minimal wages." (23)

For the many women to whom daycare is unavailable or whose wages are so low they cannot pay the cost of childcare, welfare is the only option. The stigma attached to welfare and the small amount of money available makes it a poor one. The majority of welfare recipients are women, most of them widowed, deserted, or single. Of the total number receiving assistance in Ontario in 1968 to 1969, almost half were mothers of dependent children. Welfare recipients do not receive enough to live decently, despite the fact a majority are raising children. It is important to note that a foster mother will receive more than twice the amount a natural mother on welfare receives to care for the same child. There are also limits to the additional amounts a welfare recipient can earn, and these limits are extremely low. The welfare system and minimum wage laws act as disincentives to gradual re-entry into the work force. (24)

Given the socialization, the restrictions under the law, and the absence of real opportunities in the work force, it is hardly surprising women exhibit many of the characteristics found in minority groups and even in alcohol and drug dependents. (25)

In his study on traits of victimization, Allport includes

sensitivity, submission, fantasies of power, desire for protection, indirectness, ingratiation, petty revenge and sabotage, sympathy, extremes of both self- and group-hatred, and self- and group-glorification, display of status symbols, compassion for the underprivileged, identification with the dominant group's norms, and passivity. (26)

Compare this list with that of researchers like Terman and Tyler, and Silverman, when they enumerate traits found in girls—sensitivity, conformity to social pressures, response to environment, ease of social control, ingratiation, sympathy, low levels of aspiration, compassion for the underprivileged, and anxiety. Compared to boys, they found girls were more nervous, unstable, neurotic, socially dependent, submissive, less self-confident, held lower opinions of themselves and of girls in general, and were more timid, emotional, demonstrative, fearful, and passive. (27) "The two most essential aspects of this 'minority group character structure' are the extent to which one's perceptions are distorted and one's group is denigrated." Freeman suggests these two aspects are very effective means of social control. "For if one can be led to believe in one's own inferiority, then one is much less likely to resist the status that goes with the inferiority." (28)

The extent to which *socially appropriate* female behavior is equated with minority or deviant behavior is further substantiated by recent studies by Dr. Inge K. Broverman et al. Sex-role stereotype questionnaires completed by 79 clinicians (46 male and 33 female psychologists, psychiatrists, and social workers) revealed that:

1) There was high agreement among clinicians as to the attributes characterizing healthy adult men, healthy adult women, and healthy adults, sex unspecified;

2) Clinicians had different standards of health for men and women;

3) Their concepts of healthy mature men did not differ significantly from their concepts of healthy mature adults;

4) Their concepts of healthy mature women did differ significantly from those of healthy mature adults, and healthy mature men;

5) Clinicians were likely to suggest women differ from men by being more submissive, less independent, less

adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more easily hurt, more emotional, and more concerned about their appearance. (29)

"What was judged healthy for adults and for adult males was, in general, highly correlated with previous studies of social desirability as perceived by non-professional subjects." (30)

Aside from the very disturbing equation of female mental health with adult social undesirability, these studies reflect the blatant double standard of health held by clinicians—the people who "help" women.

Add to this the findings of the Cooperstock studies which showed that 24% of all prescriptions written were for mood-modifying drugs. Of these prescriptions, 69% were for women who accounted for 56% of patient visits to general practitioners in Ontario.

"Thus research has found more women than men going to physicians, more women than men receiving prescriptions for any drugs, and an even greater disproportion in the number of women receiving prescriptions for mood-modifying drugs." (31)

The findings are hardly surprising. A survey of ads in medical journals found women appeared most often in those for stimulants or tranquillizers, while men appeared in ads for drugs for specific diseases.

Prominent theoreticians in psychology reinforce the sexism of professionals in the field. Bruno Bettleheim states that "as much as women want to be good scientists or engineers, they want first and foremost to be womanly companions of men and to be mothers". (32) Many other equally notable people such as Freud, Erikson, and Rheinhold, echo these words.

Admittedly, another view of women and their potential is beginning to be heard. And there is increasing publicity about how women have been "brainwashed" by their upbringing, their education, and the mass media into "accepting" their inferior role.

The difficulty with this increasingly popular and simplistic view is that it is misleading: It ignores the realities and suggests women can overcome the obstacles simply by changing attitudes.

A woman must face the consequences any time she attempts new options. Treatment, therapy, or advice which fails to take account of the structures and institutions of our society as they relate to the definition and restriction of women, is irresponsible and unrealistic. It is understandable some believe woman's role is changing. There is a lot of talk and publicity announcing it. The proclamation of International Women's Year is the most obvious example. However, a closer look reveals nothing has changed. International Women's Year has been adopted by governments to convince us the problems women face are created by attitudes, not by concrete limitations. For example, the advertising campaign with the slogan "Why Not?" has consistently referred to the problem as attitudinal, not structural, making such statements as:

> "Are we so conditioned into believing that only men have careers that we automatically hesitate when we reach the fifth rung on a ten-rung ladder?"
>
> "When it comes to employment, the same kind of archaic thinking brings us less pay and recognition."
>
> "We have to start thinking of ourselves as equals."
>
> "It's not a slogan, it's an attitude that says no one will ever again deny you an opportunity just because you're a woman."

The federal government focused on media campaigns, art festivals, and regional conferences, rather than making any significant changes. Only 34.4% of the recommendations of the Royal Commission Report on Women (1971) have been implemented by the federal government; few of these were major recommendations. (33) The provincial governments have also done very little to change the position of women.

Women on welfare continue to receive starvation wages for work they do in the home and continue to be regarded as people who "choose" to "live off the government" despite the fact there are no jobs available to them and no daycare facilities.

Those who do manage to obtain daycare and jobs outside the home (although they remain responsible for the work in the home) are still exploited. Equal pay for work of equal value has not been guaranteed in any legislation. So women continue to work for less pay than men doing essentially the same work. Those who must work have no choice but to accept low-status, low-paying "female" jobs. Without quality daycare available to those who need it, and without job opportunities and decent wages, it is ridiculous to speak of women having a "choice" between home and work outside. The government publicly acknowledges change is necessary, yet they have done nothing to create it. Why?

The issues which are central to women's lives are daycare and work. If they are not given the opportunity to support themselves adequately—and are indeed prevented by all manner of obstacles from earning a decent living—they are forced to remain dependent on men, or the government. Universal access to daycare and full participation in the labor force will continue to be denied to women—because to provide them would mean the virtual collapse of the economic system.

Daycare to meet the present needs could be provided by the government now although it would require a substantial shift in budget priorities. But daycare and full employment are not amongst government priorities because the labor market cannot even accommodate the existing work force. If more women were freed to work outside the home, they could not find jobs. They simply do not exist.

When it is necessary for the economy to employ women, the government can and will facilitate the process. History substantiates this. During World War II when most of working-age men were sent overseas to fight, workers were needed to fill their places in industry, particularly in the manufacture of war goods. Women were encouraged to work in order to meet this need. In addition to psychological inducements, daycare centres were established everywhere. Women responded and met the needs. However, when the war ended, so did the government's need for women workers, and so did the government's help for women.

"Three quarters of the nurseries were closed down, despite opposition by parent groups. To ensure that daycare did not grow, the federal government withdrew its financial

support and called upon municipalities to pay 50% of the operating costs of daycare, and all the capital costs. This placed the burden on the level of government with the least revenue, and effectively hindered the movement of parents trying to keep centres open." (35) Simultaneously, the government began a massive propaganda campaign to remove women from the paid labor force. (36)

Two things are clear: 1) There are not enough jobs in this society for all those who want to work, and 2) women are considered expendable and are the first to go when the labor force has to be reduced.

The experience in World Wars I and II proves the government would provide services such as daycare if their economic interests required it. The needs of women are not considered because women in this society function as a reserve labor supply which can be used when necessary and cut back when unnecessary. (37) The ways in which women (as well as immigrants and youths) are kept in this position include — lack of daycare services; welfare subsistence which keeps women dependent and afraid; labor discrimination which ensures women continue in low-paying, low-status jobs; lack of adequate and safe birth control information and techniques; and severe limitations on information and access to abortion.

Women's role is not changing, because the circumstances which define that role are not changing. Because we are exposing the lack of choices women have, the illusion is that changing attitudes will change the role. Although women are told they can be anything they want, their attempts can only end in frustration. They ultimately must face the realities of the situation.

The illusion that if attitudes about women change, the role of women will change, is dangerous. Only collective action to change the economic and social system which creates these attitudes will result in any real change in the role of women.

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On Women and on One Woman

by Helen Levine

It has been with great difficulty that I have approached the question of women as providers and consumers of social and health services. The issues for me are at once personal and political, individual and global.

The fact is, I happen to be the consumer and provider of social and health services that I know best. I have been on both sides of the desk—the institution, and the helping professions. This will be the first time that I have been ready to put some of my own consumer experience on the line publicly. However, I find it pointless to write in generalities, when my own situation has had such a profound impact on how I provide service and how I perceive the consumer. It seems important to add that in using one women's life experience as provider and consumer, I am, I hope, illustrating much of the content of every woman's life.

The Personal and the Political

The concept of "the personal and political" is central to this paper. For me, the two *are* inextricably interwoven. The personal *is* political and vice versa.

Ms Levine is a lecturer at the Carleton University school of social work.

The early 20th Century suffragette movement fought valiantly for votes for women. However, it did not address the broader social and economic framework as such, or the personal lives and experiences of women in home and family. Its failure to do so has been judged by some to be a key factor in the diluting of the future political impact of voting rights for women.

It is only by addressing the political--the broad social and economic issues--that we can begin to reshape the very system that has been a dominant influence in every woman's life.

The artificial division between the private and public spheres of life in this century are desperately in need of fusion. Thus the determination of the contemporary women's movement to weave the personal and political aspects of life into a unified whole.

Women in Society

I would like to draw your attention to my premise that human behavior, be it individual, family or organizational, is shaped primarily by the social and economic institutions of any given society. Thus, the values, roles, expectations, and social controls that affect women's lives in this society are rooted in our politics and practice of individualism and the free enterprise system.

Women are a numerical majority (52%) and a psychological minority. How or why did this contradiction emerge? My belief is it has emerged out of a particular social and economic order that has successfully, and unfortunately, conditioned and socialized women into a dependent and subordinate role in private and public life.

We are taught from early childhood to be predominantly gentle, sweet, pretty, thin, sexy, nurturing, dependent, and passive—in other words, "feminine". We learn to do a lot of waiting and a lot of smiling, and to submerge the parts of us that do not fit our socially designated primary role.

From early on, we are molded into future wives, mothers, and housekeepers, who will play a nurturing, subordinate role to men. Most of us have been trained to be

content for the most significant part of our lives, to remain in the private sphere of human existence, and to leave decision making and power in the public sphere to men.

To persuade women to remain "in their place", many pseudo-scientific theories and romantic myths have been evolved—the pedestal theory, Freud's approach, theories of human nature, the concept of normality, role theory, biological determinism, etc. The social sciences in their fast-growing awesome authority after World War II, managed, in that era, to move women out of the labor force and back to the kitchen, all the while convincing women it was of their own free choice.

Despite the myths of strong, working men protecting and nurturing weak, fragile women, the fact is women have always worked—hard. They have worked as unpaid service labor in the home, without recognition. And masses of working women have historically been low-paid, overworked, underappreciated, essential workers in our factories, hospitals, restaurants, and offices. Whatever the class, whether carrying two jobs (at home and in the labor force), or one, women have been exploited in service/object roles in relation to men. Given the family structure, and the social controls exerted by the system, this society often gets two workers from a nuclear family for the price of one.

I think Nellie McClung (1873-1951), a renowned Canadian writer and activist, describes best the hypocrisy built around women, work, and the family. From *In Times Like These*, McClung writes:

> *"These tender-hearted and chivalrous gentlemen who tell you of their adoration for women, cannot bear to think of women occupying public positions. Their tender hearts shrink from the idea of women lawyers or women policemen, or even women preachers; these positions would 'rub the bloom off the peach', to use their own eloquent words. They cannot bear, they say, to see women leaving the sacred precincts of home to earn enough to keep the breath of life in them, who carry their scrub-pails home, through the deserted streets, long after the cars have*

stopped running. They are exposed to cold, to hunger, to insult--poor souls--is there any pity felt for them? Not that we have heard of. The tender-hearted ones can bear this with equanimity. It is the thought of women getting into comfortable and well-paid positions which wrings their manly hearts."

What are the effects of this socially and economically determined role for women? There are many. Women, like other minorities, internalize the values and perceptions of this society. Given carefully prescribed behavior norms, women have a hard time being confident, resourceful, self-focused, independent, or aggressive. In fact, we are expected to be the opposite and censured severely, directly and indirectly, if we exhibit what are seen as masculine traits that do not fit the female stereotype.

We are slotted into a particularly deadly responsibility in the current nuclear family. There, women not only have been trained to exchange domestic and sexual services for economic support, in various subtle and not-so-subtle ways. We are also generally held responsible for the happiness of husband and children, and frequently blamed if one or more family members get into difficulty. Family breakdown has traditionally been blamed on women. If we work, we neglect the family. If we stay at home, we are placid and unmotivated. If we are active in community, we are social butterflies. Put the husband in any of these same slots, and the positive associations emerge--hard-working, dedicated to children, community-minded. The double standard relates to more than sexuality.

So, most women in this society have been and/or are, within that inner, private self, consciously or unconsciously, angry, guilt-ridden, fearful, and followers of men. This, despite our human potential for joy, life and growth, and this despite our little known and less recognized achievements, publicly and privately, against overwhelming odds. We have only begun to rediscover and appreciate our own "herstory", our own past.

Women fear the dominant culture (men); generally, we need to please and to be accepted, for fear of not being

chosen or noticed, or of being abandoned, having once been needed; we live with a basic insecurity, a low self-esteem, and a sense of inferiority; we try to be indispensable to family, friends, employers, so as to survive financially and psychologically; we are frequently grateful for our employment outside the home, our limited achievements, our low pay on the job; we marry to start life anew only frequently to find ourselves trapped into dependence, financially and personally; we experience sometimes devastating guilt when we demand of others what others have demanded of us, or demand to be nurtured instead of wishing to nurture others; we have, as all oppressed groups, an underlying resentment and anger about being made into second-class people, and about living daily with the psychic and material abuse such a position implies.

Are there joys, satisfactions, worthwhile challenges in many women's lives? Of course there are. But given our socially and economically designated service role, and given the purpose and aims of this particular seminar, it becomes essential that we address and expose the basic oppression, alienation, and fragmentation in women's lives in this society. Men are oppressed as well, but it is the double oppression of women, within the family and in the work force, that creates our second-class minority position.

Myself as Woman

I am a member of a nuclear family, with a husband (28 years of marriage) and two grown daughters.

From early childhood on, directly or indirectly, I was carefully conditioned to recognize, in a very central way, that my personal success or failure in life would revolve around being chosen as girlfriend and then wife, producing children, and maintaining the family unit at all costs. I followed the prescription, I thought out of my own totally free choice, and have since lived and struggled with the inherent structural contradictions within the current nuclear family system.

Of course there has been warmth, affection, a sense of belonging and caring that we all need and thrive upon. But for women, the nurturing, service role has, in the long run,

extremely serious implications in both private and public spheres of life.

My husband, in his role, was worker, husband, father, and decision maker. In a money and achievement-oriented society, where his work and job title and earning power were visibly valued, it was predictable that he would gain in confidence and competence through the years and I would lose. It was not for lack of trying.

I worked outside the home parttime for years. I was involved politically for years. But I was always in subordinate roles and often questioning my own competence and capacity for decision-making and leadership. Always deferring, in the end, to men.

I am and have been a political activist from the time of World War II.

The current women's movement grew partially out of the second-class, subordinate role in which politically committed women found themselves in the 1960s. It was the Black civil rights movement in the United States that triggered a new consciousness among women that any oppressed or disadvantaged group must close ranks, develop a sense of solidarity and respect among themselves, and stop gauging their worth by dominant standards of measurement, otherwise known as "social science", or rational thinking.

The parallel for women in the 60s was that it appeared the height of hypocrisy to struggle against oppression wrought against others whilst silently colluding in our own, in the family and on the job, and often with male radicals who espoused ideals of liberation, equality, and the just society.

I wish to state unequivocally that my concern with political issues, other than the women's movement, remains strong and clear. But a new and central dimension has been added, without which all political movements will be irrelevant to me. I believe that women really must "hold up half the sky". And I no longer am overwhelmed or intimidated by the political arrogance and mystification of some men. Without the full and central involvement of women in political or social movements, there will be no fundamental social change.

I am a member of the Women's Liberation Movement.

As a result of my own life experience and my political involvement, I gradually moved towards grappling with the question of women in society in this way. For me, the women's movement means consciousness-raising, in a personal and political sense, action geared to social change both in and out of the family, for myself and other women. I have learned from my job as lecturer at the Carleton University School of Social Work that my really effective work there stems mainly from collective effort.

I have been a practising social worker off and on for 28 years.

I wish to comment on some of the principles and practices of traditional social work which I know because I have been part of the field.

I worked parttime on contract or on a freelance basis for social agencies. I do not think that way of working was accidental. It was designed to leave my primary responsibilities to home and children relatively untouched, to deal with my guilt about leaving home at all in the early years.

It left me "free" to escape frightening work expectations and bureaucratic agency demands, as a fulltime worker. In addition, working parttime left me time, energy, and freedom to be politically active, an essential, though very fragmented, part of my life.

I do not want to leave the impression there was little of value in the past. There was much and, for myself, I am convinced that past contradictions and learnings have led invaluably into current struggles for change.

However, here is a list of the critical features of traditional practice that I believe have been problem areas for both consumers and providers of social and health services:

- An emphasis on personal adjustment and conformity to prevailing societal norms and systems. Conversely, an absence of political and social involvement on the part of most members of the helping professions in changing those systems or norms which were wreaking

havoc with peoples' lives.

- A fear of political involvement and of risk-taking personally and professionally; a vested interest in respectable professionalism, and thus a reinforcement of the status quo.

- A "case" emphasis on treatment via the medical model, on pathology, and on an assessment and diagnostic approach to the consumer.

- The formality of titles, office interviews, and sometimes home visits, the latter primarily to poor homes and families; a planned and well-defended psychological and social distance between professional and consumer; mechanical timing of appointments sometimes unrelated to consumer needs, often related to professional income; sometimes lengthy files available only to professionals, case conferences, etc.

- Hierarchical institutions and work settings where power and decision making rest in the hands of a select few, invariably men. A supervisory system that often infantilizes and sometimes paralyzes the effectiveness of direct service workers, often women.

- A creation of dependency in the consumer despite verbal and philosophical commitment to self-determination, mutual respect, and human dignity (i.e. women on welfare).

- A non-recognition of particular minority needs and status—of women and native peoples, for example—despite intellectual recognition of cultural differences.

- A mystification of consumers and the general public with jargon, "expertise", and status.

- A role in helping a social system to stigmatize, and thus render impotent, different groupings of consumers who do not fit prevailing social norms, and are frequently subjected to deeply-rooted punitive and blaming societal attitudes. For me, this method of social control is dramatized most profoundly by playwright Bertholt Brecht in *The Threepenny Opera*.

- A non-sharing of personal skills, information, life experience, and relevant literature in a one-up, one-down relationship.
- An absence of working and organizing together with consumers for social and economic change.
- Until recently, and still very prevalent, direct and indirect acceptance and reinforcement of traditional roles in the current nuclear family, and the institution of the family itself. Role reversal, in Nathan Epstein's *Family Therapy Schema,* was seen as a major maladjustment in the family, which was said to require leadership by the father.

Myself as Consumer

I have been primarily a consumer of physical and mental health services, both in and out of hospital.

One traumatic experience in middle age stands out, when I was hospitalized for a severe depression. It would take volumes to describe fully my experiences and those of others I grew to know in a psychiatric hospital. Suffice to say, I learned and grew far more out of bitter personal experience than as a professional.

Following are some relevant excerpts from my diary, written in a small womens' ward, in the least objectionable of psychiatric institutions in Canada. Names are fictitious, facts are not. All doctors and senior administrators I encountered were male.

* * *

"Article in Maclean's magazine re sleeping medication used in hospitals, a critique—includes 300 mgs of noludar which I get. No wonder my hands shake when I attempt to pick up the tiny cuplet for medication or water. I give the article to the night nurse to read but she is busy with paper work. I think this hospital uses medication far too liberally--most are on fantastic dosages of medication or shock."

"A strange, awesome experience being with such a mixture of different kinds of human beings, most of whom I would never encounter in ordinary life. Jane, funny,

restless, with her own special wisdom and sensitivity. (Committed by her husband, thought she was going out to tea that day.) Heather, now much better, almost beaten to death by an alcoholic husband, has nightmares constantly. Kay, terrified of shock, had it once before. They are trying to pressure her into consenting, husband and she are refusing. Bravo, poor Kay, I hope you don't become so demoralized here that you or your husband decide not to consent but to submit."

"Many patients go home weekends. Jane couldn't wait. Not so with me. I have no desire to go home, to be caught up in the same domestic situation of house, family, friends, and job problems."

"My husband and daughter seem to be getting along very well...he has a much lighter touch than I and she responds with laughter and ease. A burden slipped from my shoulders when I saw how well they were doing, with my husband taking over for the first time in a meaningful way. I feel less guilt. What a shift in emphasis from that ridiculously intense mothering role, feeling solely responsible for whatever difficulties befall my child."

"Susan has ended 20 shock treatments, is on heavy medication, is the kind of person so often described by feminists—dependent, fearful, lacking in confidence, sex object, having to ask for money, servicing husband and children."

"Chronic women's wards, I've made sure I have seen them all in this place. It's frightening! Mostly older women, sitting, staring, either silent or confusedly trying to reach out with words to people who cannot or will not understand. My God, they look so hopeless and helpless. Women tied into baby-tenda like infants during the day. They often scream and cry."

"Sitting in Jane's room. She's had a rough day. Reacting to medication, can't speak clearly, salivating. Instead of doctor cutting back on drugs, he increased them. Result—Jane is immobilized, weary, legs buckling, hot and cold flushes, mouth almost paralyzed. She had been trying so hard to be 'the good patient', to cooperate, to explain, to take everything despite painful ears, heavy head. She had to fall apart today, literally, before anyone became concerned."

"Jane finally broke down and cried, was so grateful that I cared about her. Martha and I agree that no one gives a damn about you around here when you're sick or upset. Bitchy Nurse X was her usual condescending self with Jane, giving some glib explanation re menopause. Hospitals are really not designed for sick people."

"Kay had her first shock treatment today. She had refused consent, her husband finally gave his, and Doctor X finally told Kay he would drag her down with four orderlies if she didn't get with it. So much for patient consent, be it for shock, drugs, or anything else."

"Ladies this and ladies that—a condescension that permeates doctors, nurses, and institutions. Some noble exceptions but a general milieu that puts patients in their place and is lacking in basic respect. Dehumanizing for people who are already alienated and desperately need genuine human contact above all else."

"I am boiling! There is so much distrust around here, so much snooping and not levelling with patients. Jane's husband turned her private writings from home over to the doctor today—as evidence! Husband complained she was so busy writing letters she did not have his supper ready when he returned from work. Then the 'expert' male doctor questions 'his' female patient as to this seemingly inappropriate behavior. My anger mounts by the minute—there must be a lot of anger buried deep in women in this goddamn patriarchal society."

"Susan says at supper that her social worker discussed her depression with her husband, and told the husband not to share this information with Susan. Don't they all know that trust is basic? Guess not—they see all patients as a bunch of mental incompetents who must be treated as children, and labelled."

"One of the problems, I said to Martha, is that this whole experience is made so demeaning. It's not enough that we have to cope with stigma in the outside world. The world of the hospital takes away all your self respect, if you allow it to. I guess you either toughen up or sink—there doesn't seem to be much in between."

"There are at least four of us on ward B6—all clearly

middle class and articulate--who challenge orders and react openly and negatively to authoritarian approaches. It's a class thing, this business of dealing with staff. We four are given far more leeway and many more options because we demand them. The others tend to take orders unquestioningly. It's like affluent parents and schools, and low-income parents and schools where people expect to be kicked around and not listened to."

"Saw *Long Day's Journey into Night* on TV. I identified with the drug addicted mother, smitten with guilt and anguish, repetitively going back to her early sorrows after marriage."

"A funny incident. I yawned, loudly. Three nurses run to my room. A hilarious moment, worthy of the Marx Brothers. Then I recall the night I was so sick and tortured when no one came or cared. Such is the irony of life in a hospital."

"Marleen is a woman in her early 40s, alcoholic from 'sipping secretly'. Separated from husband and two kids. She is so bloated, so jaundiced, so discolored, and close to death many times. Was an operatic singer who gave up her studies when she married. Husband was super-critical of everything she did and would mimic her singing viciously. She had little confidence and wanted to please, so gave up her beloved singing."

"Susan thinks I'm crazy not to go home--I have such a nice husband. Barbara agrees. How simple it all sounds to people who haven't shared the same experiences and goals."

"Women's Liberation is badly needed here. Most of the doctors are men and consciously or unconsciously deal with women's problems oppressively. The nurses are like colonials, ordered around by the doctors, then in turn taking out their frustrations on patients."

"Shirley is in an open anteroom with husband and lawyer, weeping. Their new home, jointly owned, is being switched to husband's sole ownership. My God, can't they even afford her some privacy in this place--they could have used my room."

"The doctors are really criminal drug pushers, except they don't get arrested like the street people. Once patients are on medication and shock around here, they're beyond

using exercise, the outdoors, etc. It's all ass-backwards."

"I usually hide away when I cry. The snoopy staff record absolutely everything. They see psychiatric nursing as observing and recording every piece of behavior, and handing observations on to the doctors. Such stupidity. Patient as object, doctor as God, nurses as investigators. The good feeling I have today is that I don't give a damn what they record, that's ME."

"Last night I brought out my song books and Jane and I sang all the old, nostalgic songs. We even got old Mrs. Smith, who wanders about dazed and fearful most of the time, to join in. Sure enough, she knew many of the words to songs like Maggie and Endearing Young Charms. It was beautiful and tragic at the same time. Soon a group congregated and had a bit of fun. My God, it would be so easy for staff and patients together to animate some action on B6. Unfortunately, staff do not see this as their role."

"I had made a decision re living away from home and a kind of terror descended on me re the decision and the aloneness. My doctor, as usual, came through. I'd never put up with Doctor X who barely sees his patients. Jane caught Doctor X in the hall recently to tell him of the wretched side effects of the latest needle. He insists on continuing, said: 'I wouldn't do anything to hurt you', and walked away."

"A doctor here has published a book. In it, he says: 'Equality in marriage is destructive, as in any "management".' He is for equality for women OUTSIDE of marriage, in society at large. This is precisely why women have to join the personal and political."

"Lent my doctor *Women and Madness* by Phyllis Chesler. One of the male administrators peeked at the title and said, nauseatingly: 'They sure go together.' 'Of course,' said I, 'in this rotten patriarchal system.' Jane was so impressed she insisted I put it in my diary."

"Susan told me all about her sex life. How George demands sex every night and mid-afternoon, if possible. Gets furious if rejected and reminds Susan she is being supported by him. Sounds as though he uses her as a machine. Susan's doctor seems to identify with her husband, asks how she would feel if George were not interested in her

sexually! Most doctors here are culture-bound MCPs."

* * *

As consumer, in and out of hospital, I was "helped", as were others, to see my problems as individual, pathological, personal, and blameworthy. I was not helped--except by myself, other patients, some friends, and the women's movement —to see myself as only one of millions of women with similar life stresses and strains that cried out for political as well as personal solutions.

The fact is from childhood I, as a girl-child, had been prepared, under the rigid social controls of this society, to fill a primary role of dependent wife, mother, and home-maker. It didn't fit me, personally, but that was irrelevant, and so gradually I became a failure in my own as well as others' eyes. I also became a rebel.

My experiences, particularly in hospital, taught me to distrust contemporary professionalism and institutions. Sometimes the most human and thus most effective staff were non-professional, everyday people such as nurses' aids and RNAs (Registered Nursing Assistants), whose humanity and simplicity seemed to have been better preserved than that of many professionals who were more interested in the hierarchy and the institution. It was the former, for the most part, who could talk of their own lives as well as ours, who dealt humanely and respectfully with the simple, practical realities that helped patients take hold more confidently. They didn't have to pretend, it seemed, or to hold on to precious images of status and authority, and thus could more spontaneously share and communicate and help.

I do not wish to make a case against knowledge, skill, and a well-developed philosophical framework. But I do wish to make a case for a totally different use of such assets by the helping professions. And to expose and deplore the current use of professional training as a route to membership in a small well-paid elite that separates itself out from the commonality of life experience and thus, at times, renders itself useless and/or harmful.

The dehumanization of the professional is coming more and more to the fore, both in and out of institutions. We who know it from both sides of the problem have a special

responsibility to expose the issues.

Perhaps the excerpts from my diary, which I am only now strong enough to share publicly, will have helped clarify the meaning of what is called treatment as a prime method of social control.

As women are the most numerous users of psychiatric and medical facilities, and of public assistance, we can begin to see the enormity of the problem for women. As the decision makers and senior people in the helping professions are by and large men, it is not difficult to see how effectively women have been conditioned to give up control of their own lives.

When professionals and bureaucrats deplore the escalation of mental and physical health problems in this country, and say that what we need are more of the same kinds of services and more of the same kinds of providers of service, I say, with conviction, that is a part of the problem. It is not the solution.

Personally and politically, I know women are drugged, in and out of hospital, to keep us silent and subdued. I know more and more women are resorting to alcohol and drugs in a desperation born of trying to cope with and adjust to our incomplete, everyday lives.

I know the deadly guilt, anxiety, and stress that is frequently borne by women in the wife and mother role. I know the pretence women try desperately to maintain about the joys of motherhood, the joys of sex, the joys of nurturing others, and the joys of self-denial and service.

The social controls work well for this society and women have most often submitted except in times when a few, or many women, have struggled together personally and/or politically for changes in their lives. How many unknown, unsung women are being or have been destroyed--battered physically, psychologically, and economically by this system?

One Small Way To Begin To Tackle the Problem

It is out of my experience as provider and consumer of social and health services that I have developed one area of work I

call feminist counselling. My decision to pursue feminist counselling was a partial effort to use the skills and experience I already owned, as both a provider and consumer of social and health services, in trying to join the personal and political in working with women. It began as my attempt to translate into social work action, my new and changing perceptions of women in society.

Feminist counselling has sexism at the heart of its rationale, with the clear implication that services planned, designed, and frequently delivered by men in authoritative positions as "experts", have done incalculable harm to women as consumers and practitioners.

It has for me integrated my experiences as consumer with my capacities as provider, in a way that would otherwise not have been possible. It takes a large, workable, oppressed segment of society (women) of which you and I are a real, living part, and attempts to make a small but significant contribution to the total question.

People say to me: "What is feminist counselling?" I have no absolute answer or blueprint. What I do know and have practised is a helping process that means working with women, individually or in groups, around their life situations as related to the society that has shaped them. It has to do with a "vision of the possible", out of our own oppression and involving our own potential. It is no mysterious, professional technique.

Counselling by whom? In a sexist society, by women counsellors, I would say. Not all women qualify because many have clearly adopted the values of a male-dominated society. Those who do qualify are women with life experience, commitment, and skills (the order is not accidental), women who recognize sexism and its personal and political consequences, women who are actively seeking change for themselves and others from this perspective. Previous training may be useful for feminist counsellors, but many women have other valuable qualifications for such a role. A few exceptional men may qualify but, by and large, their record as helpers of women has been a dismal failure.

I am often asked: "Isn't feminist counselling just good counselling?" My answer is a firm no. Feminist counselling

is intrinsically different. These are some of the differences I have identified.

- I call myself a feminist counsellor to state my own position clearly. A consumer looking for help has a right to know the bias or the politics or ideology of the practitioner, clearly and explicitly. All practitioners have a bias, consciously or unconsciously (the traditional practitioner has a sexist bias), and potential consumers should have some personal information before they begin to use the helper. A first session usually has to do with sharing information about one another. I need to know what the problem is and if I can help. The consumer needs to be free to ask how I work, to explore my attitudes and experience, to check out such facts as she may deem important—if I have children, if I have worked inside and/or outside the home, if I am divorced, etc. There is no neutral ground here, just two people exploring whether one can help the other.
- Does feminist counselling mean imposing an ideology on others? I think not. For me, it means sharing my experience and my view of women's place in the world when it seems relevant, when it pertains to the consumer's life struggles, or to aspects of my own that may be helpful regarding the issue at hand. Consumers of feminist counselling may or may not move into or out of the women's movement, into or out of politics, into or out of marriage. That is a personal decision to be made with full knowledge of costs and benefits, and with the advantage in feminist counselling of not having oppressive societal norms reinforced about what women should or should not be.
- A feminist counsellor uses her own life experience, her own defeats and victories, her sorrows and joys, her traumas and learning if relevant to the consumer's life situation. It is a peer kind of relationship. The focus, however, remains on the consumer who needs the help.
- We are usually on a first name basis, or we both use last names. We share, as women, many of the same dilemmas

in life, and this is the political and personal reality, as we work together.

- No formal assessment, diagnosis, or treatment is involved. One central assumption of feminist counselling is that "individuals' problems are not viewed as individual pathology, but as a manifestation of social disorganization." (*Social Service Delivery: A Structural Approach to Social Work Practice,* Middleman & Goldberg, 1974). It is understood that chronic responses of guilt, self-blame and depression are built into the structure of a woman's life. This approach does not deny the validity of one woman's personal pain and her need to express that individual hurt as she chooses or needs to. But the roots of her fear and pain and anger are recognized and then, in time, may be translated into some form of personal and/or political action. From passive, helpless pain to active, hopeful struggle, from dependent acceptance to independent assertion, at whatever level and whatever pace the person chooses or can handle.

- Fees are geared to income. No OHIP (Ontario Health Insurance Plan) coverage, a current maximum of $15.00, or free. It is not a highly commerical undertaking. People usually meet with me in my living room because it is informal, quiet, and personal. It takes away from the usual institutional aura and significantly reduces the psychological distance and barrier created by desks in sterile offices.

- An underlying assumption of feminist counselling is that women have strength, potential, and the will to change their situations, especially in concert with other women. It is recognized many women suffer from that curse of minority groups, low self-esteem, and that this reflects societal distortions perpetrated on people. Certainly women do not need male, sexist authority figures to reinforce their low self-esteem. We need other women and society in general to recognize and reinforce our strengths, to nurture our confidence.

- Women often have difficulty in truly acknowledging, to self and others, the depth of our sense of inadequacy in this patriarchal society. Trained to pretence, we need help in asserting our mix of strength and weakness.

- Feminist counselling recognizes women are deprived of nurturance. Traditionally, we do the nurturing, the entertaining, the nursing, the appointment keeping, the understanding, the child care, the worrying. That is all part of the sex role stereotype. The fact is women need "wives", meaning reverse nurturing. Instead of helping a woman to accept the nurturant role, the counsellor helps her, and sometimes the family, to recognize her central and essential needs as person.

- There is an absence of jargon, of professional mystification, of mechanistic techniques. There is simplicity, clarity, and sharing, with the simple acknowledgement that the consumer needs help. It may be the provider who at some other point in time has been or will be the consumer and this is made explicit. The consumer is not seen as adjunct to a family but as a separate person, in relationship to others in her world.

- A feminist counsellor knows a woman's loneliness in a personal and political sense. She understands the risks involved in staying in a nuclear family or leaving, in being a single parent with children, in being on welfare, or in a job ghetto. A feminist counsellor knows the isolation of women, one from the other, with husband or male friend often the main point of reference. She recognizes a woman's need for a network of support and services—not traditionally provided by society, but begining to emerge from the women's movement.

- A feminist counsellor usually finds it most helpful to work collectively, both at a personal and/or political level. Women learn from one another, from sharing lives they have been taught to keep private, from finding new ways of tackling the struggle. The feminist counsellor may have been a member of a consciousness-raising group and/or other women's action groups herself.

- A feminist counsellor shares information and knowledge with the consumer recognizing it may be vital in dealing with the problem at hand (i.e. *Handbook for Women on Welfare*). Literature relevant to women's particular needs is often most helpful and usually well known to the feminist counsellor. There is an underlying recognition that knowledge is power and must be shared.

- The feminist counsellor knows the newly developing, ever-changing services for women in the community. She knows them from the inside as part of the women's movement. So instead, for example, of referring a woman to Manpower, she may refer to a Women's Career Counselling Service. It is often a personal referral to known people in women's centres, CR groups, interval houses, women's studies courses, women's career counselling, rape crises centres, etc.

- Assertiveness training is sometimes used by feminist counsellors to help women recognize and claim their civil and personal rights. Women are traditionally taught to submit and conform, not to demand and protest. So confidence and assertion must grow in a central way if things are to change. Role playing is one interesting form of assertiveness training and can deal with past or current situations, large and small--demanding time and quality care from a doctor, rearranging domestic chores with one's mate, laying claim to equal pay for work of equal value, joining a union, working out a relationship with mother, father, or child.

- Feminist counselling recognizes women's need for achievement and involvement in society at large. Though men verbally glorify women's roles in the home, they seldom wish to exchange. Women, on the other hand, often need and want the ego satisfaction and self esteem that comes of work or achievement beyond the home, in the public sphere. Being Somebody's wife or Somebody's girlfriend or Someone's mother negates a woman's ego. Hans Selye has recognized that universal and basic human need to care for the self. Men recognize it for themselves, women are supposed not to have it. A feminist counsellor will recognize this common human need in women and encourage its development.

It is partially true some factors I have mentioned might also be part of good counselling. However, who it is done by will transmit attitudes and value systems, consciously or unconsciously, that nurture or deny the objectives noted.

It is in relation to the family and to politics that feminist

counselling reflects major differences. I would like to underline the centrality of the nuclear family structure in our society, as an institution which has been used as a particularly effective vehicle in the oppression of women. It is also the institution that most of the helping professions strive to uphold in its traditional form, no matter what the cost to women in the process.

The Here and Now for Me

I would be still trapped and lost, in a profound sense, if I had not, with the support of other women, struggled bitterly for my own personal, intellectual, and occupational needs within my family. I now have an intense sense of urgency about my work, a whole area of life that I missed out on earlier as a woman. It can never be made up and I am limited by a 52-year-old's physical and emotional capacity to invest in my own goals.

The wisdom of age tells me nothing in life is absolutely equal. But for the rest of my active years in family and community, I want primary consideration in my choice of pursuits and I need the personal support system my husband can provide—as I once did—to help make that possible. The women's movement has been an important countervailing support system for me in a culture weighted in favor of men. It has helped me to struggle for a sense of centrality and importance, both personally and politically.

Without that movement and the support it offers, I would not have understood that my behavior and feelings are common to most women, rather than unique to me. I would not have understood that the economic and social system has created institutions and value systems that dilute, diffuse, divert, and distort womens' historic struggles for social change.

I am no longer willing to collude in the oppression of myself and other women—half the world—in the name of any profession or any movement for social change that does not actively, visibly, and effectively promote the full and unequivocal citizenship of women.

Conclusion

Where am I now, as provider and consumer of social and health services?

As consumer, I know how important it is for me, together with others, to struggle for women's rights, women's dignity, and women's potential, in both the private and public spheres of life.

As consumer, I recognize I am only one of all womankind, with more similarities than differences with other women, and with more to be learned and gained from working together than separately.

As consumer, I know what a thin line there is, if any, between being a provider and consumer of service, and how the experience of one can profoundly enhance the other.

As consumer, I know now what it means to be helpless and dependent upon culture-bound and sometimes destructive practitioners and institutions.

As consumer, I now recognize, in my gut, the dangerous power and social control that providers of service potentially have over a consumer's very existence.

As consumer, I have learned how very limited my perceptions and actions were as a provider of service, and how much I and others must learn, in an ongoing way, from consumers. The following quote perhaps best sums up my own point of view.

> "Consumers are making the point with increased stridency that 'human' services are not human, that they are ill-conceived, that they are palliative fragments designed by those with biased frames of reference who lack sufficient knowledge about the users, and that history reveals their failure. Consumers are questioning the nature and form of services; they are questioning the arrogance of the providers; and they are questioning the professionals' competence. These 'Who says so?' questions attack doctors' control over health systems, teachers' control over parents in educational systems,

and social workers' control over clients in social service systems." (*Social Service Delivery: A Structural Approach to Social Work Practice,* Middleman and Goldberg, p. 4).

As provider of service, I will clearly never be the same since my breakdown.

But, as my experience was and is very personal and political, so too will be yours. I do not think the assumptions or philosophy of feminist counselling need remain in one place, with feminist counsellors only. I do not wish to see new ideas and possibilities removed from the mainstream of practice. My hope is that with a sense of history as well as of future possibilities, providers of service will pick up some of these ideas and learnings and translate them, in their own ways, into practice.

Though I align myself clearly with the Women's Liberation Movement and, for myself, consider that taking a private and public position on such questions is crucial, I believe there is no single correct line. One of the strengths of the movement today is its readiness to absorb considerable diversity and experimentation in tackling both the process and the product of change for women.

There are and will be inevitable struggles and clashes and contradictions among women because of differences in experiences, in practices, and in ideology. Every living social movement and every living profession has its intense pulls and tugs, its own strengths and weaknesses.

Let us not, as providers and/or consumers of service, identified or not identified with a specific Women's Liberation Movement, back away from this essential dialectic.

The Alcoholic Woman: Attitudes and Perspectives

by Winnie Fraser

I had my first experience with the care of women alcoholics in 1954 as a student nurse in a psychiatric hospital. In those days, they were brought in unconscious. Others were admitted in the same state to general hospitals. In both cases, they were usually deliberately misdiagnosed to guard against their discovery...to protect them.

Yet, even then, there was a wide variety of classes of women being admitted--contrasting testimony to the stereotypes of the alcoholic woman that existed then and still cling.

To some extent, the situation has improved. Now some women are coming in and asking for help. This is encouraging. It indicates the stigma of alcoholism may be slightly diminishing. But only slightly.

Even in the 1970s when there is so much talk of liberation there are hundreds, perhaps thousands, of women alcoholics. And from discussions with many women, I think it's the stigma that is keeping them hidden.

Ms Fraser, program coordinator, Northern Addiction Services, Yellowknife, Northwest Territories, was acting head of the Addiction Research Foundation of Ontario's detoxication unit at 410 Dundas Street, Toronto, at the time of writing this paper.

The term alcoholic applied to anyone--male or female -- is often misunderstood by the public at large. But, applied to women, the term almost inevitably conjures up the image of the skid row derelict.

Indeed, for those of us in the field, there is no question at all: The woman who drinks is subject to far more criticism and is far more misunderstood than her male counterpart. I can not impress this upon you enough.

Who are women alcoholics? Of course, they come from every walk of life, and in all shapes and colors and sizes. But I myself tend to see them in roughly three categories--perhaps the most common ones are those I call the "women behind lace curtains". Then there are the single career women and, finally, the skid row women.

Behind Lace Curtains

We may not have many lace curtains around any more but we do have suburban swimming pools and backyard patios. Where once the hidden woman alcoholic sat demurely behind the lace curtain, she may now sit drinking her 10:30 a.m. gin and tonic by her pool or on her terrace. Certainly, she exists. She may drink for a variety of reasons--loneliness or depression or anger or all of these.

To her neighbors and friends, she may well appear to be the respectable woman next door. At cocktail parties she will be very careful not to expose herself. For a while she will succeed.

Because she wants to look respectable, she learns to be cunning at hiding her alcohol. She may keep it in preserve jars or vinegar bottles. I know one woman who keeps her alcohol in her teapot. When she has friends over for coffee, her friends drink coffee; she pours her cocktail from her teapot.

Typically, this woman is between 35 and 45 years of age. While her children were growing, she did not take the time, or perhaps did not have the time, to involve herself in community activities. Nor did she work towards her own personal growth and identity. Now she no longer feels needed or worthwhile.

Her situation is further aggravated by her husband who continues to move in his job or career. The gap keeps widening and she turns to alcohol for her instant answer.

Although such problems are not new, living in the 70s has brought with it a whole new set of crises.

Until recently, being a wife and mother was apparently being a successful woman. Now, much of the world is telling her that is no longer the case. This vicious cycle is, in turn, aggravated by a constant barrage of demands from television advertisers. She cannot be the glamorous wife, super-mother, super-efficient housekeeper she is exhorted to be by television. But, at the same time, she feels she must try to live up to the expectations--the television's, her family's, and her husband's.

While she may be struggling to live up to television's idea of her, her husband may well be wondering if he is the only man in the world who hasn't got the perfect wife. Gradually crumbling under her own search for perfection, as well as the demands and expectations of others, she sinks into hopelessness and helplessness. The veneer of respectability dissipates and she becomes the overt chronic alcoholic.

Single, Professional, and Career Women

These women differ quite considerably from the women "behind lace curtains" and may have more in common with their male counterparts. Like them, they may keep their bottles stashed in desk drawers. They have one additional advantage--large handbags.

In my experience, the career woman alcoholic has never married or is divorced or widowed. Many have interesting, fufilling jobs. The problem begins when they return home at the end of the day, the excitement ended. Because they have not always learned how to fill the void, they drink.

Some of these women have described desperate loneliness, particularly at nights and on weekends. Occasionally, they say, they have found themselves drunk in the corridors of their apartment buildings, knocking on doors--perhaps to borrow a bottle or perhaps just to talk to someone.

They have either not learned the importance of establishing a social life for themselves or have let it go. Play for them is extremely important. But like the wife and mother, the career woman may have neglected her social life in favor of her business life. While the wife and mother is trying to cope with that role, the career woman is trying to cope with the pressures of the working world, with working in what has been traditionally "a man's world".

Many of these women have no girl friends and, in fact, some seem not to trust other women. This is one area where women's consciousness-raising groups have been a great help. Women are learning to be sisters to each other.

Some take in men out of loneliness or desperation or because they cannot tolerate the thought of spending the rest of their lives without male companionship. For them, as for their homemaker sisters, there is very little help available. Certainly they receive little at work. Most of the companies which employ our larger work force have no company policies regarding women and alcohol problems. Many of the women are afraid even to say where they work in case employers discover their secret.

Skid Row Women--A Way of Life

The skid row individual is a socially isolated person who, because of physical, emotional, and/or educational disadvantages, is unable to participate successfully in our complex and highly competitive technological society. As a result, she depends for her physical, economic, and social survival on an ad hoc collection of facilities and services (i.e. missions, flophouses, day labor agencies, pawnbrokers, emergency departments of hospitals). These provide for her immediate needs for survival but accomplish little in the way of encouraging personal independence.

One reason we do not see skid row women as often as males in the police files or on the streets and in the parks is because traditionally Tarzan will not allow Jane to stay out alone in the park or where she may be in danger. So Tarzan carries Jane off to a safer environment where she then becomes involved in the "revolving rooming-house syndrome". This is mainly in the inner core of the city.

I would classify these women as semi skid row women, dependent upon men for survival, using sex as a means to continue alcohol consumption. The rooming-house relationships are often short-term but these women appear to have no difficulty finding another man and another room. These women could also be classed as "hidden". The situation can, and often does, continue until the woman has lost her youthful appearance, which comes quickly, largely as a result of alcohol abuse.

At this stage she panics and seeks a lasting relationship which is now very difficult because her personal growth has been stunted. Physical appearance rapidly deteriorates and often a 22-year-old woman looks 35, a 35-year-old woman can be taken for 52, and a 52-year-old for 65 or 70. It is usually at this stage that these women have their first exposure to a detoxication centre, via police referral. Police are called in because of domestic violence.

These women are difficult to place in a too-structured rehabilitation area and often require custodial care at this stage. They may do quite well in a therapeutic community where they can assist eventually in the management of the house.

I know of some skid row women living in seclusion--one woman literally digs a hole in the ground and crawls into it. Another woman spends her time frequenting laundromats until she is picked up by the police.

A chronic alcoholic at age 45 usually starts to drink in her late 20s or even earlier. The average age of women in our centre is 45 years.

Depending on their circumstances, these women have had contact with some community services. Very significant among these are doctors and police.

Why do we have to wait for them to hit rock bottom before help begins?

Doctors

On their way to becoming chronic alcoholics, almost all these women seek the help of family doctors. Because of shame and guilt, however, they often deny the real problem,

resorting to complaints of other ailments--gastroenteritis, back pain, fatigue, and injuries sustained in accidents in the home. Often, they talk their doctors into prescribing tranquillizers.

Many family physicians are responsible for cross-addiction in women patients, sometimes without being aware of it. For example, one 45-year-old professional woman, after admitting to her daughter that she was an alcoholic and needed help, was referred to our detox centre. After a brief discussion with staff, she was still unsure whether this was the place that could offer her the help she needed. She called her family physician who advised her to leave the centre and go to a psychiatric unit of a general hospital where she would receive diazepam (Valium) to help with her withdrawal and would have immediate access to a psychiatrist.

As this woman had been addicted to diazepam for several years and was now chemical-free, she was made to feel even more ambivalent about her decision. We advised that a) she and her daughter spend as much time as they wanted in the unit talking with the other women who were there for help; b) she go through withdrawal without the help of diazepam; and c) only she could make her own decision.

Her decision was to remain where she felt comfortable. She was amazed that she was even able to sleep a few hours on her first night there.

Police

If most of these women at some point see a doctor, some of them also eventually run up against the law--through drunk driving, public inebriation, or domestic problems.

Both male and female police officers find women alcoholics difficult. A woman picked up as a public inebriate or an impaired driver has reached a very low ebb in her life. It is often in her confrontation with police that her long pent-up anger finally surfaces. This may be one reason why several studies suggest women alcoholics are more difficult to deal with than their male counterparts. However, the woman who is drunk in public is less likely to be arrested, charged, convicted, and jailed if she has social

status, money, or is in a higher economic class.

A Crown Attorney in Toronto women's court admits: "We're generally very lenient with women--they just plead guilty and walk out. The judge usually grants a suspended sentence in most cases, feeling a night in jail drying out is enough punishment."

But, do they belong behind bars because facilities for them in Ontario are inadequate?

One woman visiting friends in suburbia on a weekend, consumed 30 ounces of alcohol. She became acutely intoxicated and violent to the point where police had to be brought in. Police said that as there were no detox beds available they would have to place this woman in a police cell.

Police officers have long recognized that the police station's "drunk tank" is simply one phase of the "revolving door syndrome". They have seen that the practice of jailing the chronic drunkenness offender was expensive for society and often damaging for the offender. They have realized that, at the very least, it did not benefit the offender or encourage her to change her behavior. The Metropolitan Toronto Police have therefore been more than willing to cooperate with the Addiction Research Foundation in the operation of its Toronto detoxication unit.

Inspector Marks says policemen who take people to the unit come to be great appreciators of its work. One added benefit, as far as police are concerned, is the impact detox units have had on the suicide figures. "Our figures show 28 suicide attempts in 1971," said Inspector Marks. "Of these, 23 were made by people charged with alcohol-related offences. But out of the thousands of these persons we've taken to detox units, there's never been an attempted suicide. I think that speaks for itself. The detox simply represents a far better way of handling cases of this kind. These people respond to their peers a lot better than they do to policemen in uniform. For many people in the skid row culture, in fact, a police uniform is like a red flag to a bull."

Police have also noticed a change in the behavior of many of the people they pick up as chronic drunkenness offenders. These people now seem to realize that if they

respond in a more positive way they may end up in a place that is better for them than jail. In this way, the officers' work has actually been made a little easier.

410 Dundas Street

If many women alcoholics find their way to a family doctor at some point, and others to the police, a few eventually find their way to detoxication centres. I am, as you know, supervisor at the detoxication centre of the Addiction Research Foundation Clinical Institute at 410 Dundas Street in Toronto, the only coed detox in Southern Ontario.

We have facilities for six women and 14 men. In all of Ontario, there are 25 beds for women and 265 for men. The manner in which this priority is assigned is determined, to a large extent, by general population characteristics.

The goal of our centre is to provide recovery facilities for people who require detoxication and to give them further information about ongoing treatment available to them. To accomplish this goal we direct our efforts towards:

1. Maintaining an attractive residential setting with a cosy, home-like atmosphere because detoxication represents the first stage of treatment.
2. Conveying to residents our positive feelings about their personal worth and their ability to change their present life style if they wish to do so.
3. Promoting the residents' involvement in ongoing treatment and support programs.
4. Liaising with medical and support services in the Metropolitan Toronto area, e.g. emergency and out-patient departments, social service agencies, halfway houses.
5. Working closely with the courts as a result of the introduction of Bill 101 under which people are no longer prosecuted or incarcerated for public inebriation. This is important as the courts are not consistent in their approach. They give one person a sentence of incarceration whilst others go to a detox centre.

Admission Criteria

We give priority to: a) men escorted to the unit by police from #52 Division; b) women escorted to the unit by police from any part of Metropolitan Toronto; and c) people referred from the emergency area of the Clinical Institute of the Addiction Research Foundation.

As beds are available, we admit people who require detoxication provided they do not require immediate medical attention and are not in a state of severe withdrawal. If they require immediate medical attention, they are referred first to the emergency department of the Clinical Institute. All admissions are voluntary and the maximum length of stay is seven days.

While the above descriptions may characterize the population for which the system of detoxication centres was established, we see a cross-section of socio-economic groups, since it would be unreasonable to deny these facilities to those who voluntarily present themselves for assistance and who are less in need.

What Kind of Population?

Based on preliminary statistics, the men and women have many demographic similarities, but their behavior is quite different.

Women generally present many more management difficulties than do the men, during both their admission and their stay. They are usually more deteriorated than men, physically and emotionally, and more abrasive, more aggressive, and perhaps also more manipulative. While they take longer to detoxify than men they do not stay as long and are much less willing to become involved in further treatment. This may be for several reasons. Firstly, society's expectation of the role of women is such that once they are on the street they have lost much more in status both in their own view and in society's than men in similar circumstances. Secondly, the women do not socialize among themselves or have the same camaraderie that is apparent in the male population. While the men who come to the unit often meet the same men they were drinking with several days previously, this is rarely the case for the women. Also,

women tend to isolate themselves and are much more difficult to engage in discussion. Thirdly, there are fewer treatment facilities available for women.

On many occasions, we are asked how we handle the violence and manipulation of which alcoholics are often accused. One answer may be we are not only non-medical but non-institutional and seem to avoid these behaviors.

With our relaxed atmosphere, and staff treating each person as an individual and not a label, we go beyond manipulation. Seldom, if ever, do we have violence, with the possible exception of some women who have been brought in by police or clergy.

As for reasons for drinking, many of the women I have talked to say that when they drink they feel more warm, loving, sexy, and sensuous. Men, on the other hand, say they feel stronger and more aggressive. Both sexes have great difficulty in developing male/female relationships.

Women also claim there was no lack of love in their family, but in discussions about how parents displayed affection it becomes apparent affection was either non-existent or the parents had great difficulty expressing it. That beautiful feeling of love and awareness flowered only through the consumption of alcohol.

Because they are at a low ebb when they arrive at detox, and usually look it, we do not have any mirrors in our first day admission room or our "tender loving care unit" of three beds. Later, when they are feeling and looking better, they want to see their own reflections. During the first few days of admission they also find it more difficult to mix socially and in the informal group sessions.

At this time, women require a great deal of support from staff and it takes great skill in personal interaction to handle the woman alcoholic. Sometimes, because of lack of beds, detox staff have assisted families via the telephone.

Seeing a recovering alcoholic make a new life style for herself encourages the detox worker to continue to develop skills.

Residents' Time

The extent of resident involvement depends a great deal on

their physical well-being. While the degree of discomfort associated with withdrawal from alcohol varies from individual to individual, withdrawal is generally characterized by tremulousness, nausea, visual and auditory hallucinations, disorientation, and possibly convulsions. It is most important to note, however, that severe withdrawal does not occur in the majority of admissions for detoxication. We have had only two cases of full blown DT's, and both were cross-addicted. Generally, we have found that approximately two days after admission the majority of residents are able to begin to discuss future plans.

Participation in the program is voluntary and activities are matched to the individual's health and ability. Housekeeping in the unit is the responsibility of the residents. They also prepare their own breakfasts and lunches with the assistance of staff. Interestingly, we are rarely without a resident chef or short-order cook. The evening meal is prepared at the Clinical Institute and delivered to us.

After Detoxication?

I believe a woman alcoholic needs two weeks of detoxication before referral to a structured rehabilitation program. For those who decide to accept referral for comprehensive treatment, we can offer out-patient or in-patient care at the Clinical Institute, a halfway house, the Coed Spadina Project facilities, out-patient contact at any one of the branches of the Addiction Research Foundation throughout the province, plus Alcoholics Anonymous, and all of the treatment services available in the community. For those not interested in referral, we attempt to make arrangements for accommodation, food, and clothing, and encourage them to return to the unit if they change their minds. Often when it appears a woman has refused treatment, the fact was a facility for her particular needs was not available.

Although we refuse to admit people who have been violent or unmanageable over several admissions, we do accept people for repeated admissions. We feel this gives us an additional opportunity to work with someone very much in need of help. To deny the admission, would be to say "we are no longer prepared to help you".

Conclusion

We pick up lonely, broken human beings at the detox centre. Many of them have literally fallen on our doorstep. Although I do not feel there are now more women alcoholics, more women are looking for help. (Even though the average age is between 35 and 45 years, we see many women aged 16 to 29 years.)

Each of us, whatever our area, must remember that for the woman alcoholic, whether she is a suburban housewife, a career woman, or a skid row woman, we might be the first person in a long, painful, and lonely time to accept her. Not as a failed wife, a failed mother, a failed executive, or a no-good, but as a woman and a person.

Women and Legal Drugs: A Review

by Patricia Badiet

In reviewing the literature related to women and legal drugs, I have emphasized women's role in society. I have done so for the purpose of discovering the way in which writers and researchers in this field have linked women's role with their use and misuse of drugs and with their denial of the problem. Further, I wished to discover if women's role has influenced the perceptions of researchers, designers, and providers of service, resulting in the inadequate development of both preventive and treatment services for women.

Women and Alcohol

The Stigma

While the excessive drinker is still looked down upon by even the most developed society, present day society will not tolerate a drunken woman. This special stigma for women has been acknowledged by a number of researchers (Sclare, 1970; Wilsnack, 1973; Curlee, 1968-70; Chalfant, 1973; Schmidt and de Lint, 1969; Rathod and Thomson, 1971; Lisansky, 1957 and 1958; Senseman, 1966; Johnson, 1965; Deshaies, 1963; and Mangano, ND).

Ms Badiet is a social worker with the Children's Aid Society, Ottawa.

The reason for the stigma would appear to be the strategic place women hold in the family as wives and mothers. In women, alcoholism represents the breaking of stronger taboos. It runs counter to the "American ideal" of self-controlled, "lady-like" behavior (Lisansky, 1958).

Drinking and drunkenness have been more tolerated in men. In fact, such behavior is considered a sign of manhood by some groups. As women are historically the guardians of social values, their abuse of alcohol is seen as a threat to family stability: When they deviate from the female role, they are even more threatening than their male counterparts.

Curlee (1970) pointed out that because woman's role has been equated with the stabilizing functions of wife and mother, the drunken woman seems to be a special threat: "No one likes to believe that the hand that rocks the cradle might be a shaky one." Her role as mother and wife calls for constant vigilance to others. While business demands may be put off for a day, demands of children cannot.

Such social prejudices do not prevent addiction but they do discourage women from admitting their problem and seeking help. Rubington (1971) estimated that 70% of women alcoholics in the United States were hidden drinkers. Friends, doctors, police, and judicial officers tend to protect women alcoholics. The higher the social status, the more protection they receive (Senseman, 1966; Johnson, 1965; Cramer and Blacker, 1966; Wood and Duffy, 1966).

The role of the housewife makes concealment easier. She has more time and opportunity to drink secretly. She can shield her drinking for a number of years (Lindbeck, 1972; Mangano, ND; Curlee, 1970). When husbands finally realize the problem, they frequently use denial themselves because of the stigma. They tend to keep their knowledge secret for fear disclosure will reflect on their ability to "control" their wife's behavior and also, on their masculinity (Lindbeck, 1972). Husbands cover up for their wives and therefore hinder referral for treatment (Lindbeck, 1972; Lisansky, 1958; Curlee, 1970; Chalfant, 1973). Thus the hidden alcoholic remains hidden.

Women tend to drink alone at home and hide their drinking while men more often drink in public places and in

the company of other men (Lisansky, 1957; Senseman, 1966; Johnson, 1965; Schuckit, 1972; Lindbeck, 1972; Mangano, ND). Those women who do drink openly often come into contact with the law (Lindbeck, 1972; Lisansky, 1957). However, because of their secret drinking, women alcoholics do not come into contact with the law as frequently as men do. When they are arrested for public drunkenness, they are treated more leniently than men by police officers and judges (Fraser, 1973).

The Stereotype

The female alcoholic as she emerges from the literature, is neatly painted by Sclare (1970) and Schuckit (1972). She is a 35- to 45-year-old drinker of spirits who is likely to be divorced or separated. She has a one in six chance of having an alcoholic spouse, has about a 50% chance of having a psychiatric illness, and she has attempted suicide in 33% of the cases.

Schuckit, Pitts, Reich, King, and Winokur (1969) found two major groups of female alcoholics: primary alcoholics, whose illness has not been preceded by any form of psychiatric illness; and affective disorder alcoholics, or those whose drinking problem is accompanied by pre-existing emotional disorders.

Family histories, when compared to those of men, show a marked increase in incidence of affective disorders in first degree female relatives as well as an overall increased incidence of alcoholism in all first degree female relatives. Onset of drinking occurs at a later age for women than for men, but women lose control of their drinking faster than men (Sclare, 1970; Lisansky, 1957; Deshaies, 1963; Wanberg and Knapp, 1970; Rathod and Thomson, 1971; Schuckit, 1972; Lindbeck, 1972).

Johnson (1965) found in her study of physicians that housewives drink to excess to escape routine, to improve their own self-image, and to give them confidence, rather than in response to crisis (Johnson, DeVries, and Houghton, 1966).

On the other hand, Curlee (1969) suggests the onset of drinking in women is more often related to a crisis situation

in their lives. She describes the middle-age identity crisis or "empty nest syndrome" and says a significant number of women begin drinking when their children leave home or their husbands die or divorce them. Without their children or husbands to depend on for their own identity or sense of worth, these women turn to alcohol. The drinking only compounds their feelings of self-disgust and a vicious cycle is created.

The literature review would seem to point to class and age differences. Hidden drinkers do not seem to conform to the stereotype of the alcoholic: They tend to be well integrated personally and socially and present no problem to their families or themselves. Parker (1972) found female alcoholics do not indulge as much in spree drinking as do males. He felt this would be a more serious violation of the norms of the female drinking pattern. Spree drinking does seem to occur more among lower-class women. Cramer and Blacker (1966) found that women alcoholics from marginal status class tend to be more isolated from social contacts than those from the lower class.

Mangano (ND) found the greatest frequency of alcoholism in the age group of 40 to 49 years, among subjects with higher education, in public services, or in business, and with alcoholics in the family background. She found few alcoholics among women who are the sole economic support of the family.

Many researchers have concluded it is a popular misconception that homosexuality or promiscuity are particularly characteristic of women alcoholics. Gomberg (1974) and Lisansky (1958) concluded the stereotype of the promiscuous woman alcoholic may be based on women who display their alcoholism publicly and get into difficulty with the law. They felt sexual promiscuity may be associated more frequently with this particular subgroup of women alcoholics.

Wood and Duffy (1966) found that while female alcoholics have difficulty accepting their feminine role, this does not justify the charge of promiscuity. They concluded from their sample that the most typical woman alcoholic is a "respectable" woman who drinks at home and does not get into trouble. They reported that the marriages of their patients, while unsatisfying emotionally, were long-lasting

and free from infidelity. Johnson (1965) said physicians in her sample were not agreed on this subject. Some felt women were promiscuous, while others felt their patients kept good contact with their families. While women may cause greater devastation than men, they are less likely to stray.

Sicker than Men?

When women finally go for treatment they are considered to be sicker than their male counterparts and more difficult to treat. Rathod and Thomson (1971), in a comparison of 30 female and 30 male alcoholics, found that 30% of women in their sample and no men had suffered from affective "depressive" disorders needing treatment prior to problem drinking. Thirty-six percent of the women and 6% of men had histories of suicide attempts.

Wood and Duffy (1966) concluded there is a basic psychopathology underlying female alcoholism despite widespread social and cultural differences. Belfer, Shader, Carroll, and Harmatz (1971) also supported the "sicker" concept of females. They said females have more basic personality disorders, are more hostile, angry, self-centred, depressed, and emotional than their male counterparts. Female alcoholics also show less insight into their problems and are less "likeable".

Some researchers, however, claim the more telescoped progression of alcoholism in women is caused by the greater stigma.

Curlee (1970), in her study of 100 male and 100 female alcoholics, found nothing in MMPI patterns that would provide evidence that woman alcoholics are psychologically sicker than men. The women in her sample, which was drawn from the middle and upper class, had received more psychiatric treatment than men, had more suicide attempts and had experienced more marital disruption. Curlee noted that such women might have been considered sicker because they had received more treatment but that such a conclusion must be tempered by the societal attitude toward women. Particularly for their class, society finds it easier to recognize a woman as mentally ill than as alcoholic. It is easier for a husband to decide his wife is mentally ill and

send her to a psychiatrist or hospital than to decide she is an "inebriate" and send her for treatment. Because women must break through more social taboos, they are thus thought to be sicker.

Curlee (1970) believed women feel especially degraded because of the stigma. They share society's opinion of them and are likely to suffer more self-loathing and self-contempt than men do. This severe ego-devaluation might make it more difficult for women to recover.

Lisansky (1958) also believed women are subject to more repression than men and therefore build up more tension. The woman's alcoholism, when it is thus released, is more vehemently expressed, in proportion to the tension. Women might be judged to be more abnormal because they deviate more from the norm of feminine behavior.

Schmidt and de Lint (1969) found no difference in mode of death between male and female alcoholics and concluded that perhaps female alcoholics only *appear* more abnormal as they deviate from the expected.

Feminine Role Rejection

A number of researchers have found that specific precipitating circumstances or crisis situations play a larger role in the development of alcoholism among women than men (Wilsnack, 1973; Curlee, 1970).

Podolsky (1963) suggested sexual problems are particularly significant as precipitating factors in female alcohol addiction. Premenstrual tension may serve as a significant stress factor for the female alcoholic. Gomberg (1974) suggested premenstrual tension is used by women because of their need to justify their drinking. Physicians in Johnson's (1965) study felt women drank to relieve tension.

Parker (1972) found sex role preferences becoming less feminine as drinking increased. He questioned whether this "deviant femininity" is the *cause* of the drinking or the effect.

Curlee (1970) questioned whether the same factors which make it difficult for a woman to accept her distinctive physiological functions might also make it difficult for her

to accept her femininity in general and thus predispose her to alcoholism.

Lindbeck (1972) and Lisansky (1958) found it significant that the specifics of causal circumstances, such as premenstrual tension, marital troubles, menopause, etc. are often related to women's adjustment to and acceptance of their femininity.

Wilsnack (1973) found that alcoholic women do not consciously reject the maternal role but rather value it to a "hyperfeminine" degree. She concluded the basic wish of the alcoholic woman is not to be a man but rather to be a more adequate woman. Researchers have assumed these women were maladjusted as they were rejecting their femininity.

Kinsey (1966) said it is the failure of the person to adjust to roles, previously internalized, which is a source of chronic tension and anxiety leading to inebriety. It is, in other words, a conflict between strong emotional identification with femininity and tendency to reject the feminine role. Gomberg (1974) was not surprised to find that the problem of female alcoholism revolves around the female sex role and the emotional problems generated by difficulties in making that role work.

How Great a Problem?

Perhaps because of the stigma and the consequent hidden drinking of women, researchers have found it difficult to pinpoint the exact ratio of female-male alcoholics. Many believe alcoholism to be on the increase particularly in view of the fact social drinking among women is now more acceptable. Lisansky (1957) claimed the increase in drinking among women in the last several decades probably related more significantly to changes in the role and status of women and the changing norms of acceptable feminine behavior than to increased rates of alcoholism. She felt women were drinking more because of new pressures and strains in their lives.

Others (Curlee, 1970) state the increase is not in actual numbers but rather, because the stigma for women is diminishing, in the number of women seeking treatment and being diagnosed.

In 1958, Lisansky estimated that on a 5.5:1 ratio there would be between three-quarters of a million and one million women alcoholics in the United States. The Fairfield County Connecticut Council on Alcoholism estimated there were nine hidden alcoholics for every one under treatment. Senseman (1966) reported that Dr. Marvin Block of the American Medical Association's National Committee on Alcoholism had stated there were as many female alcoholics (between four million and five million) as male alcoholics. Senseman also said the ratio in his hospital was approaching 1:1.

Lindbeck (1972) said that the ratio in hospitals was about 6:1 but that in her experience women constituted 33% of alcoholic patients in private practice. This is also believed to be the ratio of minimum current membership in Alcoholics Anonymous. Lindbeck (1972) believed while the ratio might be lower in the lower classes, in her experience it was nearly equal in the upper classes.

Some Canadian statistics, on the other hand, while indicating a rise in total numbers of alcoholics, do not suggest any change in the proportion of male to female. For example, application of the Jellinek formula to figures released by Statistics Canada, and related to death by cirrhosis, indicates that, if anything, proportion of males to females is increasing: In 1971, the proportion of male to female alcoholics was 5.8:1 and in 1973 it was 6.5:1. (1)

However, admissions to Canadian mental hospitals, for men and women diagnosed as alcoholics, indicate a slight decrease in the proportion of male to female alcoholics (7.0:1 in 1964 and 5.6:1 in 1973). (2)

Women and Their Families

Alcoholic women would appear to marry to the same extent as the general population. While their divorce rate is higher than that of the general population, it is the same as that for male alcoholics (Gomberg, 1974). There is some

(1) Vital statistics (Statistics Canada). Jellinek Formula. (A=(PD)/(K/R), where, K/R = .26, P = 62.8 (male), P = 21.6 (female).

(2) Dominion Bureau of Statistics. Mental Health Statistics, Volume 1, Institutional Admissions and Separations, 1964, 1969. Ottawa: Queen's Printer, 1965, 1970; and Statistics Canada. Mental Health Statistics, Volume 1, Institutional Admissions and Separations, 1970, 1971. Ottawa: Information Canada, 1972, 1974.

evidence that transmission from husband to wife of symptomatic drinking is not uncommon. However, it rarely works the other way (Lisansky, 1957; Wanberg and Knapp, 1970; Gomberg, 1974). Lisansky (1957) found the frequency of alcoholism and drinking problems among husbands of alcoholic women to be four times higher than for wives of male alcoholics. Wanberg and Knapp (1970) found that female more than male alcoholics drink significantly more often with their spouse.

The spouse of the female alcoholic is a relatively unknown entity. Gomberg (1974) mentioned that, in scattered references in the literature, the non-alcoholic spouse of the female alcoholic seems to react in a variety of ways--protectively, unforgivingly, with denial, anger, etc. Sclare (1970) said while little is known about the husbands' responses, marital problems seem to be the central issue that drive women to seek help with their drinking. Lindbeck (1972) found from her review of the literature, that while the spouse of the male alcoholic is usually seen as contributing to her husband's drinking, the spouse of the female alcoholic is more likely to be regarded as a deprived person who receives more sympathy than censure. Bailey (1961) reviewed the literature on the spouses of alcoholics and found it only covered wives of male alcoholics. These wives were described as disturbed, poorly integrated, insecure, dominating, masochistic, and initially dependent women with sexual problems who prevented their husbands from getting help. She found no research on the husbands of alcoholic women other than a note by Fox in 1956 that husbands of alcoholic women were generally less patient and accepting and more likely to terminate the marriage than were the wives of alcoholic men. She felt this tendency was the result of the wife's capacity to mother once she sensed her husband's illness, of her greater financial dependency, and of the greater permissiveness in our culture toward drinking among males.

Lindbeck (1972) and Lisansky (1958), from their review of the literature, note there is a difference in the attitudes of lay people and professionals toward the spouse of the alcoholic.

The non-alcoholic husband has received more sympathy and less research concentration. He has handled his wife's drinking with denial and a variety of unconstructive behav-

ioral responses and has used denial more extensively than his female counterpart.

Curlee (1970) also noted that little had been written about the husband, but there was much about the wife. She said the usual pattern seemed to be that the husband of the alcoholic first shielded and denied her illness and then, when he could no longer tolerate it, left her. The wife was more likely to stand by partly for economic reasons because the husband was more likely to be filling the role of the wage earner. The wife was expected to adjust to her husband's needs and problems. Failure to maintain a home was a mark of failure for a woman, both psychologically and socially.

Chalfant (1973) surveyed women's magazines in an attempt to assess what kind of an image women were getting from the media in regard to alcoholism. He found the alcoholic was not always portrayed or presented as male and that the role of the alcoholic's spouse was an important aspect of the whole labelling process. The wife was seen as a nagging contributor to her husband's alcoholism. Rarely did she give him support. The husband of an alcoholic wife, however, was generally seen as supportive of her problem and as helping her to recovery. He was never seen as nagging or as a martyr. While he often tried to hide his wife's condition, he was never portrayed as contributing to her alcoholism.

Chalfant remarked such unwillingness to cast the husband of an alcoholic in a negative light while the wife of an alcoholic was generally seen in such terms, was particularly striking considering that the articles examined were found in magazines directed at women.

Edwards, Harvey, and Whitehead (1973) reviewed more than 37 articles dealing specifically with male alcoholics and their wives, families, and marriages (from 1937 to 1972). They concluded that the classical clinical description propounded between 1937 and 1959 of the wives of alcoholics as aggressive, domineering women who married to mother or to control men, was shown to be inaccurate by later studies between 1962 and 1966. They cited Whalen's work in 1953 which classified these wives as "Suffering Susan", "Controlling Catherine", "Wavering Winifred", and "Punitive Polly", stating such women had married to fulfil certain personality needs of their own. In an effort to deny their own feelings

of inadequacy, these wives remained with their husbands even though they could manage financially on their own. This image of alcoholic wives paralleled clinical psychiatric literature which was complete with descriptions of the domineering mother and passive father.

Bailey (1961) noted that Jackson in her studies, beginning in 1954, was the first to advocate the stress theory which suggested that, in their efforts to handle problems associated with alcoholism, family members came to feel guilty, ashamed, inadequate, and isolated from social support. Wives were particularly affected because in their own and in society's eyes they had failed in their major role.

In the later studies, wives were found to be normal or much like other women experiencing marital problems or other stresses. Any "abnormality" in personality or role in the family could usually be attributed to a reaction to the severity of the husband's alcoholism. In contrast to the earlier theories, these wives tended to improve rather than deteriorate when their husbands became abstinent.

Women and Their Children

In addition to their concern with her effect on her husband, researchers are also becoming concerned about the effect of the alcoholic or drug addicted woman on her children. Cork (1969) pointed out that children of alcoholic mothers felt more rejected than those with alcoholic fathers. Even non-alcoholic mothers were found to be wanting and were accused of being too concerned about the drinking father. Some children felt that, while it was all right for their father to drink, drinking by their mother was "disgusting—not like a mother".

Curlee (1970) seems to be unique in her concern for the mother as well as the child. She states the mother's relationship to her children is important for her as well as for them. She feels a woman alcoholic's feelings about her children are an important factor in her feelings about herself. If she is unable to care for her children, or if her children have problems for which she may be to blame, her guilt and self-contempt may be intensified.

Yet this identification of the mother with her children, the fact she is often dependent on her husband or children

for her sense of identity and purpose, may cause her to abuse alcohol or other drugs.

Curlee (1969) referred to the "empty-nest syndrome" and found significant numbers of women who defined themselves in terms of their roles as wife and mother, began drinking to excess when their children left home. They had feelings of emptiness, pointlessness, and of no longer being needed. For such women, Curlee believed, drinking has a self-destructive element.

Women and Psychotherapeutic Drugs

Extent of the Problem

Studies dealing with the use of psychotherapeutic drugs have one common finding: Women use these drugs more than men do.

Cooperstock (1971) found that 69% of psychotherapeutic prescriptions in her sample were for women. These findings have been supported by other researchers (Curlee, 1970; Parry, 1968; Rogers, 1971).

Brahen (1973) broke down prescriptions by type. Of habitual frequent users of barbiturates and major tranquillizers, 54% and 58% respectively, are women. They use 60% of "pep pills", 63% of non-controlled narcotics, 66% of non-barbiturate sedatives, 70% of minor tranquillizers, and 80% of diet pills. Brahen also found that 73% of regular barbiturate users and 85% of those who take other powerful sedatives belong to the middle or upper class.

Nine out of 10 women obtain drugs by doctor's prescription and follow dosage instructions. However, these women move from physician to physician to maintain a drug regimen no one doctor would prescribe.

Sims (1973) pointed out that between 1962 and 1966, consumption of barbiturates increased by nearly 20% and amphetamines and related substances by more than 130% in Toronto. During this time, the population of Canada increased by only 7%. She said women were perceived by private physicians as requiring psychoactive prescriptions in a proportion of nearly three to one. While doctors see more women than men, it is not in such marked disproportion as the number of drugs prescribed.

Linn (1971) also noted the increasing rise in the use of psychotherapeutic drugs and found that 50% of women in Los Angeles were currently holding a prescription for one or more stimulant, sedative, or tranquillizer. He said since the introduction of tranquillizers in the mid 1950s, treatment of emotional discomfort had become a vast enterprise. People had come to believe that to endure any sort of distress was both ignorant and foolish.

Why Women Take Drugs

Shapiro and Baron (1961) who produced the first data on patterns of prescribing psychotropic drugs in a non-institutionalized population believe the differentials cannot be explained by variations in the rate of physician visits or in the rate at which "all drugs" are prescribed.

Cooperstock (1971) supports the notion that women are freer to bring these feelings to the doctor, but that the physician, who represents the society that sanctions freer expression for women, *expects* them to come for such reasons and thus to require a higher proportion of mood-altering drugs.

Linn (1971) found that physicians' attitudes to appropriate drug use are more likely to be characteristics reflecting values, social position, or social background, than to characteristics reflecting medical or scientific background.

Rogers (1971) claimed women are seeking prescriptions for these drugs because they are lonely, anxious, dissatisfied, or unhappy, because they are not popular, thin, vigorous, interesting, or beautiful as they have been led to believe they should be. He attributed the increase in drug use to the fact people have been convinced that psychological and social problems have medical causes and chemical solutions. Depression, social inadequacy, anxiety, apathy, marital discord, children's behavior, and other psychological and social problems of living are now being redefined as medical problems. Lennard, Epstein, Bernstein, and Ransom (1970) pointed out the role of the drug industry in this redefinition.

Advertising and Physician Attitudes

An increasing number of researchers is questioning the influence of drug advertising on the medical profession and the way doctors prescribe.

Katz (1973) questions the power and independence of the drug industry. Berg (1971) concluded from his study that because of deceptive advertising claims, millions of American women are hiding behind the chemical curtain which not only does not shield them from anxiety and depression, but exposes them to more serious illnesses. They go to doctors complaining of harmless ailments, anxieties, and fears. What they need are understanding discussions with someone skilled in dealing with social and family problems: They come away with a diagnosis of emotional illness and prescriptions for tranquillizers.

Researchers such as Berg (1971) and Seidenberg (1971), claimed that over-prescribing by physicians and attitudes physicians hold toward women, have been influenced by drug advertising.

Fidell (1973) claimed deceptive advertising has led to sex-stereotyping by physicians. Such advertisements contribute to differential treatment and/or differential behavior by women and men in the medical setting. Physicians are dismissing women's symptoms as neurotic or as "normal" female problems.

Seidenberg (1971) claimed drug companies were no longer merely suggesting a treatment for mental illness but were, in fact, encouraging a way of life. He found many advertisements appeared subtly to reinforce prejudices against women. Women were almost always portrayed as the weaker and sicker sex. They were often portrayed in their humdrum environment with the recommendation that "they could be drugged to become adjusted to their role".

Seidenberg supported other researchers who have suggested that by encouraging drug usage, drug advertising diminishes the value of and possibilities for social and political action.

Muller (1972) claimed people using such drugs were often wasting money and time that could have been invested in a superior method of improving their health. She believed overuse of drugs was maintaining itself because of charac-

teristics of the medical market. Drug companies raise the level of drug use to maximize gains. Doctors are in the position of having to balance the time available for practice against the time demanded for medical care. Prescribing is at least a means of terminating the interview in a manner that satisfies both doctor and patient.

Women as Consumers of Service

The Standard of Neglect

There would appear to be a strong consensus among researchers that alcohol and other drug research, as it specifically relates to women and their special needs, has been an area of great neglect (Lisansky, 1958; Curlee, 1970; Lindbeck, 1972; Schuckit, 1972: Gomberg, 1974).

In his review, Schuckit (1972) found the literature on alcoholism dealt primarily with male populations yielding data of questionable significance when applied to the female alcoholic. In fact, between 1928 and 1970, he found only 28 studies on women alcoholics were published in the English language. Gomberg (1974) found that virtually all psychiatric, psychological, and sociological theory about alcoholism has been about men. She claims theory and practice has been derived from men's lives and experience and it has been assumed this could be generalized to women.

Lisansky (1958), Curlee (1970), and Lindbeck (1972), in their reviews, found that most articles deal with men. Studies on alcoholism tend to ignore women entirely or assume alcoholism is the same regardless of sex.

Wilsnack (1973) found that, with few exceptions (Belfer et al., 1971; Kinsey, 1966; Lisansky, 1957), the psychological literature on female alcoholism consisted of clinical, descriptive studies of women alcoholics using neither control groups nor empirical measures.

Curlee (1970) said most studies dealt with specific populations with little effort to determine whether the same factors would also be found in other female alcoholics. Moreover, most studies have dealt with subjects from state hospitals or correctional institutions, and with samples drawn primarily from lower and lower-middle socioeconomic classes. Most have attempted to classify women alcoholics

according to personality traits and historical antecedents. Findings were often contradictory and irrelevant. The history and progress of one illness in one population has not been clearly defined. Most notable has been the fact that populations used in most cases, were not compared to normal populations.

The Double Standard of Sexism

Moralistic attitudes toward women have interfered with objective research and treatment and have severely hampered and often denied women proper treatment. The majority of staff members in treatment settings are male. Levy and Doyle (1974) in their study of a therapeutic program found a greater number of males on the general and clinical staff, and a total absence of females on the executive staff. They concluded the lack of administrative and policy-making ability appears to bias the system to male clients from the outset. Women were viewed as more emotional, more sensitive, limited by their biology, needing to please men, and implicitly "sicker" than men. Male staff members' behavior tended to suppress the aspirations of women and to disregard some of the unique problems of women in our society, and in the therapeutic community. The staff held attitudes similar to society as a whole. Schmidt and de Lint (1969) remarked on the double standards of clinicians. Therapists could unknowingly compare women alcoholics with their ideal of womanhood.

Mayor and Green (1967) claimed that to run a successful group for women, an active and authoritative leader might be required who could enforce greater controls. It was felt this might not be easy, because in spite of their intense need for them, women rebel against such controls. The success of a group with women might also improve, they felt, if either the leader or recorder could be female. In this way it might be easier to "manage" their sexuality.

Rathod and Thomson (1971) concluded that women were more maladjusted than men because five of the women compared to two of the men in their study were unfaithful in marriage prior to problem drinking; 19 women versus 15 men had experienced broken marriages; nine women versus six men had "chosen" alcoholics as spouses.

It is conclusions such as these, based on such a small sample, that call attention to the importance of attitudes.

Levy and Doyle (1974) recommended, as a result of their study, that when considering the recidivism rate of women as compared to men in the same program, attitudes of the therapist should be taken into account. They stressed the importance of women staff sharing in the role of policy-making in both management and clinical decisions. They proposed "attitudinal training of male staff members regarding the rights, roles, and special problems of female clients". (3)

Gomberg (1974) also suggested the attitude of the therapist to women and to alcoholics, as well as the enthusiasm and interest of the therapist, were more related to outcome than the technique used. Whether smaller groups would be successful or groups of women has not been systematically studied. She believed group therapy was more effective with male patients and that women were less responsive to group therapy and looked for individualized relationships. She based this on Curlee's findings (1970) that women had more difficulty in AA groups. However, the attitudes of men in these groups could also be a factor.

Curlee (1969) pointed out the importance of dealing with the devastating loss of self-worth in middle-aged women. They must be helped to discover who they are in order that they may develop a sense of self-worth, purpose, and identity. They would thus no longer be defined just in terms of their children or husbands. Curlee also pointed to a need for future research to compare alcoholic women with women suffering from other psychiatric disorders.

Many housewives who turn to alcohol or other drugs in middle age, have never been trained for work other than housework. Job training should be made important in the treatment of female drug abusers, and not limited to traditional fields such as nursing, teaching, or secretarial work.

Lindbeck (1972) stressed the importance of the role of social workers, doctors, psychiatrists, and clergymen in

(3) To test the attitudes toward women, Levy and Doyle used this measure: J.J. Spence and R. Helmrich; "The Attitudes Toward Women Scale: An Objective Instrument to Measure Attitudes Toward the Rights and Roles of Women in Contemporary Society", Selected Documents in Psychology Journal Supplement Abstract Service, American Psychological Association, 1973.

identifying concealed alcoholism in women. Women more often seek help for physical, emotional, or family problems. Developing criteria for the identification of hidden alcoholism in women would enhance prognosis for effective service.

Senseman (1966) pointed out it was hard to detect the hidden drinker but he did give criteria for doctors. Frequently, however, the woman herself does not know she is an alcoholic. Johnson (1965) pointed out that only 14% of 400 to 500 women studied went to a physician specifically because of a drinking problem and concluded that the doctor has an important role to play in uncovering the problem. Many doctors in the study believed they had a responsibility to discuss the drinking problem with the patient, but many failed to do so believing it would harm the relationship. Treatment for alcoholism is therefore often delayed or ignored as doctors do not know when and how to approach the patient. The woman who chronically complains of depression, tension, or anxiety should receive not a prescription but rather help in confronting the reasons for the emotional problem.

Brahen (1973) suggested physicians must be wary of yielding to the demand for increased amounts of drugs. Others such as Sims (1973) and Muller (1972) believe increased consumer participation in the design and management of health programs is needed. They suggest community health centres would be one method of relieving some of the burden of consultation from the doctor. Trained personnel in the doctor's office would be another.

Rogers (1971) stated the "welfare of society is too precious to be entrusted solely to the hands of physicians". He believed society may havè been basing its trust on a myth of medical competence and suggests a solution might be citizen review boards for medical practice.

Many researchers suggest constraints be placed on the drug companies and on other participants in the medical care market. Muller (1972) suggested drug advertising be eliminated from medical journals.* Other solutions include a quota system for the manufacture of psychotherapeutic drugs or the use of newer drugs with less abuse potential and

*One should note here what this would cost to the American Medical Association as an example. Seidenberg (1971) noted that the AMA receives 43% of its total income from advertising, compared to 33% derived from membership dues. The drug industry itself spends $3/4 billion per year on advertising directed at doctors.

fewer side effects (Brahen, 1973). Other researchers recommend voluntary bans on the prescription of such drugs by physicians.

Conclusion

That literature in the addictions field has tended to ignore women in terms of use and misuse of drugs seems evident from this review. The literature which does exist abounds with myths, sexism, patriarchal notions, and double standards. Women have received great attention mainly when there is concern about their effect on others (husband, children, doctors, etc).

Women have been considered "sicker" than their male counterparts. Many researchers seem to conclude that well-adjusted people would presumably show optimal degrees of preference for, and identification with, their appropriate sex roles. Under this theory, a woman must adjust to her sex role if she is to be considered healthy. Researchers do not seem to have considered the fact women might be rejecting the oppressive nature of the female role. They have not identified the common feelings of these women with regard to their role, but rather have deemed them abnormal because of their rejection of "femininity". It is the women's movement which is attempting to raise the consciousness of women around their common oppression, to improve relatedness among women, to push for changes in the traditional sex role stereotyping.

Lisansky recommended in the late 1950s that more understanding of the demands of changing sex roles in the 20th Century was needed if the problem of use and misuse of drugs by women was to be addressed effectively. Yet, it seems researchers, other professionals in the field, and society in general, continue to ignore shifting sex roles and family patterns in their treatment of women. Female unhappiness or frustration seems to have been viewed as a disease which psychotherapy or drugs could cure.

Rather than being tranquillized, women must be encouraged to examine the source of their unhappiness. Bernard (1971) suggested the cause of mental health might be better served if both men and women were encouraged toward realization of individual potential rather than to any

adjustment to existing sex roles. Researchers and providers of service in the addiction field would do well to consider Bernard's hypothesis.

Because of her traditional role as wife, mother, and guardian of social values, a woman incapacitated as a result of drug use or other causes is more disturbing than a male in a similar situation. The resulting stigma has increased the tendency for denial of a problem by all concerned. Thus, women have been handicapped in both the seeking of, and referral for, treatment. Moreover, little attention has been paid to their special needs and problems in the design and delivery of services.

Female drug abusers who are also mothers must frequently choose between their responsibilities to their children and seeking help for their addiction. Because few treatment centres offer resources such as baby-sitting or child care services, women do not seek out residential treatment programs but prefer to attend day programs. Only in this way can they realistically continue in their caretaker role and, at the same time, hope to avoid feeling condemned and guilty for temporarily leaving their children. Moreover, the majority of single-parent families are headed by women. These women have difficulties locating baby-sitting services for even short periods of time. Their worry for their children and home can only handicap treatment.

In summary, there is clearly a need for study in relation to women and legal drug use. At present, the incidence of alcoholism among women remains largely undocumented. The little information that is available is often conflicting. The societal factors contributing to legal drug abuse should also be identified. In my opinion, a correct analysis must include women's role and the way in which women are perceived.

Treatment services for women also need to be assessed so the special needs of women are a significant factor in future program design.

Such studies and many more could contribute to informing and sensitizing those who make laws, set policies, and deliver services.

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Women and Psychotropic Drugs

by Ruth Cooperstock

Women exceed men in their consumption of psychotropic drugs in a consistent ratio of 2:1. These figures hold reasonably constant over time and place, thus suggesting a certain immutability.

This paper will attempt a socio-cultural examination of the meaning of this 2:1 ratio in the hope this consultation can lay the basis, through discussion, to challenge its immutability.

Prior to any discussion of psychotropic drugs, it is necessary to recognize these are the product of a particular relationship—the patient to his/her doctor. Thus, we must first see how women and their illnesses have been viewed by doctors up to the present time.

Ehrenreich and English (1) have documented the medical profession's view of the 19th century American middle or upper class woman as "sickly" while her working class counterpart was innately healthy, sturdy, and seldom in need of medical care.

Ehrenreich (2) points out that this theory of "innate sickness of affluent women served the economic interests of the doctors...it established middle to upper class women as a

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Ms Cooperstock is a scientist in the social studies department of the Addiction Research Foundation of Ontario, Toronto.

kind of 'client-caste' to the medical profession" (p. 618) which, at that time, had an excess of doctors in urban centres.

Regardless of the symptoms presented, women's problems tended to be located in their reproductive organs; thus, genteel women risked atrophy of the uterus if they sought a higher education (p. 619). Ehrenreich notes that the prevailing medical views of women conform well to the prevailing cultural mythology regarding the proper role of women.

Modern medicine has moved far beyond this reproductive explanation of female illness to its 20th Century equivalent—the weak central nervous system or the psychologically inadequate woman. This position reached its most brilliant exposition in Freud's writings and has increasingly become a part of general medicine.

Freud and his followers saw the psychic differences between men and women as innate, essentially biologically determined and, therefore, unchangeable. More contemporary writers, looking at sex differences and mental illness in particular, have updated the inferiority of the female psyche and postulate that this inferiority is culturally rather than biologically determined; that is, the product of social roles. Gove and Tudor (3) examined the extant epidemiological studies and concluded that women do, indeed, have higher rates of mental illness than men, the result of increased stresses in women's lives since World War II.

The concept of increased stress resulting in increases in the rates of mental illness (or even psychosomatic illness or psychotropic drug use), seems to contain a logic consistent with much contemporary thought. However, that which appears logical is not that which is necessarily empirically grounded.

Gove and Tudor have chosen to define mental illness in a new fashion. Without going into great detail here, it should simply be pointed out that they equated mental illness with neurosis and those functional psychoses which, by their definition, produced feelings of distress, discomfort, anxiety, and so forth. This omitted, in their definition, all of the personality disorders, alcoholism, and other conditions which they claimed produced different symptoms and required

different forms of therapy from the former "personal distress" illnesses.

Additionally, Gove and Tudor combined in their listing of epidemiological studies, a large number of community studies which rely totally on self-reports of individuals residing in the community. These, as we shall see, consistently find women *reporting* more symptoms than men.

The Dohrenwends, in an excellent critique of the work of Gove and Tudor (4), clarify the issues in this ongoing battle regarding rates of mental illness. And they conclude that, by the standards of international nomenclature, the consistencies that exist do so within diagnostic categories and that no generalizations about "mental illness" are possible.

However, the Dohrenwends show a clearly consistent pattern, over time and place, of women suffering more neurotic disorders than men and, by contrast, of the personality disorders appearing as the male perogative. Rates of psychotic disorders appear inconclusive although about three-fourths of the studies they examined showed higher rates of manic depressive psychosis for women.

This identification of neurosis as a more dominantly female disorder, and personality disorders (those illnesses in which little insight exists and which are characterized by "acting-out" behavior) as in the male domain, becomes a starting point leading to a clearer understanding of psychotropic drug use, and seems consistent with our knowledge of use patterns.

As pointed out at the beginning of this paper, psychotropic drug use, as discussed here, can only be seen in the context of the physician/patient relationship. Before discussing the nature of this relationship, we must first explore the available data on men's and women's awareness of discomfort, i.e. reported symptoms.

Reporting of Symptoms

Women consistently report more symptoms of physical and emotional discomfort than men (5,6,7). In a large national sample, Dunnell and Cartwright (7) found women reporting

an average of 4.5 symptoms for the previous two weeks compared to the male figure of 3.2 symptoms.

For clarification, the sorts of symptoms women reported with greater frequency than men were "constipation, faintness, headaches, weight problems, nerves, backache, muscle and joint pains, palpitations, sleeplessness, undue tiredness, swollen ankles, and foot troubles". The only symptom reported more frequently by males was "cough".

Whether these differences, which appear in so many studies, reflect a greater sensitivity to one's bodily reactions on the part of women, that is an ability to feel discomfort, or simply a willingness to express any discomfort to an interviewer, remains a moot point.

After establishing a greater reporting of symptoms on the part of women, one must ask the next question: What action, if any, do men and women decide to take regarding these symptoms?

Many possible courses are open to them. The first, and probably most common, is to ignore the symptom and view the discomfort as a normal part of one's situation. Beyond this, is a wide range of possible behaviors—from talking it over with family and friends, to self-medication, to the decision to visit a doctor or hospital.

Dunnell and Cartwright (7) found that with the same number of symptoms reported, men are less likely to take medicines than women. Self-medication is a considerably more frequent occurrence than attending a physician. Coates (8), in a Toronto study, found that even at the point of perceiving themselves "on the edge of a nervous breakdown" men were less than half as likely as women to go for professional help.

Consistent with the earlier finding that women are more likely to have psychiatric illnesses whose primary symptoms are anxiety and generalized discomfort, is the fact they more frequently seek help for these discomforts (9, 10). To summarize: Whether the symptoms are vague, specific, "physical", or "emotional", women engage in more help-seeking behavior than men.

The actual decision to seek the help of a physician is related to more than the sex of the individual in Western societies.

Urban people utilize physicians' services somewhat more than rural (11), and where medical care is not covered by insurance, the middle and upper classes utilize the services somewhat more than the working class.

Within the female population, Nathanson (12), in her review of United States studies, concludes that working women have demonstrably lower morbidity rates than non-working women. She points out, additionally, that studies "are consistent in showing that the presence of pre-school children in the home disinclines women to adopt the sick role" (p. 60).

Attitudes and Perceptions

We move now to a discussion of the attitudes and perceptions of physicians in relation to male and female patients.

The first point to establish is that, as of 1975, 92% of Canadian physicians are males. Thus, we must still think of the profession as a male domain (although this proportion will be changing within the next few years).

Physicians, as a group, have their attitudes determined in a wide variety of ways--by their early experiences, by their medical education (the proportion of female teachers in medical schools is lower than that in practice), by their continuing contact with peers, continuing education courses, the ever-present detail men, pharmaceutical advertisements, and, not least, by the patients with whom they interact on a daily basis.

Myths and shibboleths regarding females still seem endemic in most medical education (13). Identifiable and treatable gynecological problems are diagnosed as psychogenic in origin (14). The negative attitudes toward female patients in medical advertisements have been studied and documented a number of times (15, 16, 17).

In view of these experiences, it is hardly surprising that Ehrenreich (2), in speaking to a physicians' gathering, asked: "...can medical men overcome the superstitions and 'old husbands' tales' that have hindered the development of scientific medicine in the past? Are they capable of objectivity?" (p. 620)

It seems important to stress that physicians' images of their patients must also be based on their personal experiences in their practices.

Because of the subordinate-superordinate position of a patient and doctor (enhancing the traditional male-female dominance) the female patient is unlikely to complain if treatments do not work. Out of the traditional doctor/patient relationship has come the commonly held notion of physicians that the patient is well if he/she doesn't complain or return.

A study of the attitudes towards, and perceptions of, male and female patients was conducted among Scottish general practitioners in 1972 (18). These physicians were in general agreement that women come to a physician for treatment of both somatic and psychological disorders at an earlier stage in an illness than do men. When asked to identify the three most common symptoms presented by men and women in various age groups (disregarding the reproductive organs), these physicians made clear distinctions between their patients as shown in Table 1 (19).

They reported a high incidence of genito-urinary problems among the young and middle-aged women; respiratory problems were most commonly assigned to the middle-aged and older men. Problems of the circulatory system were most common among older men, while musculo-skeletal disorders were common to both sexes.

Most surprising was the perceived incidence of gastro-intestinal disorders among young and middle-aged males (the most common symptoms were among young men). As expected, accidents and injuries were common only among young males. Almost twice the proportion of females to males were perceived as commonly reporting some form of mental disorder although the differences were negligible among the young males and females. It was, however, the miscellaneous category of vague, poorly defined symptoms that most differentiated these physicians' views of their male and female patients.

Table II reports the frequency with which these physicians perceived the following problems were raised by their patients.

TABLE I *Physicians' perceptions of symptoms most frequently seen in their practice by age and sex of patient*

Systemic Classification	Females 20-39	Females 40-59	Females 60 +	Females Total	Males 20-39	Males 40-59	Males 60 +	Males Total	Total
Genito-Urinary	29	29	9	23	1	2	15	6	14
Respiratory	3	—	5	3	9	13	17	13	8
Circulatory	—	2	11	4	—	13	20	11	7
Musculo-Skeletal	5	12	21	12	10	17	19	15	14
Gastro-Intestinal	2	2	6	3	24	20	9	18	11
Accidents and Injuries	—	—	—	—	21	8	—	10	5
Mental Disorders	23	31	24	27	21	15	9	15	21
Anxiety	9	7	5	7	12	6	2	7	7
Depression	4	11	9	8	2	3	2	2	5
Others	10	13	10	12	7	6	5	6	9
Social Problems	4	2	2	2	2	1	1	1	2
Miscellaneous	34	22	22	26	12	11	10	11	18
Lassitude, Fatigue	11	9	9	10	1	5	4	3	6
Vertigo, Headache	9	4	8	7	1	2	2	2	4
Other Symptoms	14	9	5	9	10	4	4	6	8
TOTAL: %	100	100	100	100	100	100	100	100	100
# Responses	(132)	(134)	(131)	(397)	(127)	(124)	(123)	(374)	(771)

TABLE II *Physicians' perceptions of frequency with which patients raised the following problems:*

	Sleeplessness		Financial Difficulties		General Feelings of Unhappiness		Marital Discord		Headache		Disobedience of Children		Loneliness		Fatigue		Inability to concentrate	
	Male %	Female %	Male %	Female %	Male %	Female %	Male %	Female %	Male %	Female %	Male %	Female %	Male %	Female %	Male %	Female %	Male %	Female %
Frequently	13	79	4	11	4	53	11	34	17	83	-	6	4	15	19	79	11	26
Sometimes	49	21	34	51	45	45	40	62	47	15	6	47	26	62	68	19	66	53
Seldom	38	-	51	28	43	2	40	4	32	-	51	41	47	17	9	2	23	21
Never	-	-	9	6	6	-	6	-	2	-	40	6	21	6	2	-	-	-
No Answer	-	-	2	4	2	-	2	-	2	2	2	-	2	-	2	-		
	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47
	100	100	100	100	100	100	99	100	100	100	99	100	100	100	100	100	100	100

It must be stressed here that these data do not necessarily reflect the objective reality of the interaction within any physician's office. They do not even clearly specify that the physician did not elicit discussion of any of the following problems--they only reflect the perception of the physician, at one moment in time, regarding his male and female patients. Each problem presented was viewed as more common among females. Some, such as "sleeplessness", "general feelings of unhappiness", "headache", and "fatigue" were dramatically more frequent. Even financial difficulties were seen as a more common female issue.

Perhaps more than anything else, this table demonstrates the expansion of the bounds of medical care. If financial difficulties, loneliness, disobedience of children are commonly seen as problems presented to physicians, then we must hardly be surprised by the increase in psychotropic drug consumption that has taken place in the past decade.

These "problems of living" have somehow become "medical problems" by definition, if only because they are presented in the physician's office. We have reached the chicken and egg dilemma and can ask the question: Would so many social, personal problems be defined as medical problems today if psychotropic drugs didn't exist? Conversely, would psychotropic drugs have proliferated as they have if the pharmaceutical industry had not helped to "medicalize" living?

As Lennard and Bernstein (20) succinctly state: "...there is hardly any doubt that professionals, through their expansion of psychiatric conceptualization to include anxiety, unhappiness, conflict, and tension as symptoms of mental disease, have themselves contributed greatly to the very psychic distress they seek to pacify through drugs. Both mental health professionals and the pharmaceutical industry have, by promoting drug-taking, promoted a model that has contributed significantly to the medicalization and technocratization of human existence" (p. 152).

Apart from a value orientation which questions this medicalization, one might legitimately ask why the concern with the increase in use of psychotropics?

It must be stated clearly that opposition to reliance on psychotropics for individual solutions to problems of living is

a value-laden position. It is consistent, however, in its opposition to large scale use of these drugs, with a segment of concerned medical opinion which sees physical problems as consequences of use.

A recent issue of the *British Medical Journal* carried an article on Psychotropic Drugs in General Practice. (21) The author points out: "Most of the psychotropic drugs in common use have some well known side effects. Barbiturates cause dependence and depression; ...tricyclic antidepressants may produce unacceptable atropine-like side effects and cardiac arrhythmia;... the benzodiazepines appear relatively non-toxic but also may produce 'hangover' and dependence. The latest worry is the possibility of interaction between drugs being used simultaneously.... Most psychotropic drugs interfere with the rate at which other drugs are metabolized, and this may lead either to prolonging or reducing the effect of other drugs in use at the same time.... Very few doctors either in hospital or general practice carry the knowledge of pharmacology necessary to predict safe and unsafe combinations." (p. 178)

Apart from the problems of dependence, drug interactions, and the inadequate training of physicians, these drugs have become the most popular method for those attempting suicide.

Weissman (22), in her review of the studies of the epidemiology of suicide attempts between 1960 and 1971 reported in the literature, notes the consistency of the preponderance of female to male attempters. The most frequently cited finding regardless of the country or time period studied is two females to one male. A typical attempter might be described as a young (under age 25) divorced or single female. The method most frequently employed was self-medication accounting for 70% to 90% of all attempts. Psychotropics led the list as the class of drugs most frequently used.

During this time period, there was a shift in drugs of preference within this class from the barbiturates to the minor tranquillizers and the antidepressants. Reasons posited for the predominance of psychotropics in suicide attempts include their increasing availability and the more obvious dilemma that "patients who most often require these

medications also offer the greatest risk for misusing them" (p. 743).

Data on Use

By now we have attempted to specify some of the meaningful variables as background to an understanding of the higher use of psychotropic drugs by women. In the following pages we will examine data on the use of these drugs, particularly in relation to utilization of physician services.

The only Canadian data available at this time is not national but provincial. Fortunately, for this meeting, the data is Ontario based. However, to demonstrate that Ontario physicians and patients seem to behave much as physicians and patients in other parts of the Western world, we will give some other national figures first for comparative purposes.

A national survey of physicians in the US conducted in 1973-74 found that approximately 40% of all patient visits were by males while 60% were made by females (23). This ratio held constant for visits to general and family practitioners.

A result that is consistent with other studies, was that a higher proportion of males was seen by pediatricians. The surgical specialties, excluding obstetrics and gynecology, also reported the 40:60 proportion; this finding is probably explainable by the high rate of elective surgery performed on women (24). Psychiatrists in private practice saw a higher than average proportion of males: 44% to 56% females. This study also found that a drug was recommended at about half of all physician-patient contacts. Parry et al. (25) report that the prevalence rates of use of psychotropics is twice as high for women as for men. Chambers et al. (26), however, point out that most of this difference seems due to the use of the minor tranquillizers, but not to the use of either barbiturates or non-barbiturate sedatives.

Hemminki (27), in Finland, found 69% of psychotropic prescriptions going to women and 31% to men. In a study of general practitioners (28) she found the doctors had made

more psychic and other diagnoses for women, but psychotropic and hidden psychotropic drugs counted per diagnosis were not prescribed to excess in comparison with these for men. The largest proportion of psychic diseases and obscure functional conditions, along with prescribed psychotropics, occurred within the age group of 35 to 49 years.

Hemminki's finding regarding the ratio of diagnoses to drugs prescribed is particularly interesting as this suggests that a "labelling" process may be a factor at work in the physicians' approach to their female patients.

In the United Kingdom, Dunnell and Cartwright (7) found that men visited their physician an average of 2.9 times per year while women did so 4.2 times. (It should be noted that somewhere between 20% and 30% of the population in the US, the UK, and Canada, never see a physician in the course of a year.)

In their national sample of UK adults, Dunnell and Cartwright asked about drug consumption in the two weeks prior to interview. Seventy-five percent of the women and 60% of the men reported taking a non-prescribed medication during that time, while 50% of the women and 33% of the men had taken a prescribed medicine. Thirty-one percent of the women and 20% of the men were taking a medicine prescribed more than a year before the interview.

Of special interest were the consumption figures for drugs acting on the central nervous system. It was reported that 10% of the adults (13% of all females and 6% of males) had taken a tranquillizer, sleeping medication, or sedative in the previous two weeks.

In a large-scale survey in South London, Wadsworth et al. (6) found that women mentioned more health problems than men; the areas showing the greatest differences in consultation rates between men and women were mental, digestive, and rheumatic disorders.

Significantly more women than men consulted a physician about these symptoms. The mean number of all medicines used by males was 1.9 and by females 2.2. After the age of 50 there was little difference in total medicine-taking behavior. Complaints of worry, nervousness, tiredness, and headaches made up 21% of all complaints, the largest category after respiratory disorders. For each of

these complaints there was more reporting by females than males.

Turning now to Canada, or more specifically, Ontario, the average person in this province receives about five prescriptions a year. Since about one-fifth of all prescriptions written are for a psychotropic substance, this translates crudely to one psychotropic prescription per person per year, with the average prescription containing just under a month's supply of drug. Before examining the data on the use of psychotropic drugs at two points in time among a large population in southern Ontario, we will first compare males and females in their utilization of actual physician visits in the province.

Table III refers to the total number of physician *visits* made by men and women for specific age groups. These data, however, do not allow the computation of the average number of visits per individual. Nor can the proportion of the Ontario population never attending a physician's office in 1973-74 be specified, although it is estimated at close to 30%.

It is known that about 7% of the population in Ontario used hospital out-patient departments for their primary medical care in that year, but this does not preclude the possibility that some or all of these people also visited a physician during this time. As this table is based on more than eight million physician visits, it can be expected that the male/female relationships found for physician visits would reflect similar relationships for individuals.

Table III is divided into two sections. The first two columns give the proportion of physician visits made by men and women in the various age groups.

Among men the highest proportion of visits was made by the very young and those over 65. From age 19 on, there was a slow but steady decline in reported visits until the category age 65 plus.

Among females the highest proportion of visits was made in the early reproductive years and then again after age 65.

The third and fourth columns in this table demonstrate within each age group the proportions of men and women reporting physician visits. The most striking figure here is

TABLE III *Age and Sex distribution of patient visits April 1973 to March 1974 — Ontario — OHIP*

Age	Proportion of Each Age Group		Proportion of Males/Females Within Each Age Group		Total (N)
	Male	Female	Male	Female	
0	2.7	2.3	51.0	49.0	212059
1-4	7.8	6.2	52.1	47.9	590424
5-9	8.8	7.0	52.3	47.7	665069
10-14	9.2	7.4	51.6	48.4	700939
15-19	9.2	9.3	46.0	54.0	785146
20-24	8.5	10.0	42.3	57.7	789011
25-29	7.6	8.7	43.1	56.9	696662
30-34	6.1	6.7	44.1	55.9	548681
35-39	5.5	5.8	44.9	55.1	479318
40-44	5.7	5.8	45.9	54.1	488468
45-49	5.8	6.0	45.7	54.3	500499
50-54	5.5	5.6	45.7	54.3	470695
55-59	4.5	4.4	46.9	53.1	374960
60-64	4.0	3.8	47.4	52.6	333643
65 Plus	9.1	11.0	41.9	58.1	860997
TOTAL	100.0 (3939131)	100.0 (4557440)	46.4	53.6	8496571

the total at the bottom which indicates that of all physician visits in Ontario in 1973-74, 46% were made by men and under 54% by women.

In other words, the overall sex differences are relatively small, with the greatest proportion of women attending in the oldest age group and in the 20-24 year age group where almost 58% of physician visits were made by women in contrast to 42% of visits by males.

Because women live longer than men, it is desirable to examine physician visits in relation to the actual population distribution in each age group. This information is provided in Table IV in which the number of patient visits to the physician per hundred persons is shown by sex for each age group.

Since it is unknown whether very few people made many visits or many people made few visits during the year, this must serve as a fairly crude estimate for Ontario. The relationships demonstrated by these figures, namely that young males see physicians more often than young females; that this relationship is reversed from age 15 through 64, with the peak difference during the reproductive years; and that a levelling off takes place by age 65 such that no sex difference in rate of doctor visits exists, are consistent with findings reported from other countries. Overall, for every 100 visits made by males, there are 114 by females.

The following four tables are based on the computerized records of all prescriptions dispensed by a prescription insurance agency located in southern Ontario.

These cover all prescriptions dispensed during 1970-71 and 1973-74 to individuals who were members of the plan during both those years. It must be noted this is not a random sample of the Ontario population but, because more than 30,000 individuals are involved, the internal comparisons can be expected to be close to those in a random sample. Caution must be exercised in generalizing from this data.

Tables V through VIII show the proportion of men and women during those two-year periods receiving anywhere from zero to 10 or more prescriptions for the class of drug shown in the title. They also give the total percentage of

TABLE IV *Number of patient visits per hundred persons in Ontario by age and sex – April 1973 to March 1974*

Age	Male	Female	Total
0-4	128	125	127
5-9	93	90	92
10-14	87	86	87
15-19	94	115	104
20-24	98	133	115
25-29	92	122	107
30-34	91	119	105
35-39	90	115	102
40-44	92	114	103
45-49	97	115	106
50-54	103	119	111
55-59	103	114	109
60-64	109	115	112
65 plus	127	128	127
Total	100	114	107

Sources: 1) *Province of Ontario, Vital Statistics for 1973,* Table B (Estimated population of Ontario, by sex and age groups, 1973), p. 13.

2) Age and Sex Distribution of Patients, April 1973 to March 1974, Ontario, OHIP

those receiving one or more prescriptions for the particular drug class during the one year and, on the bottom line, the percentage of men and women who received a prescription for the class of drug in 1970-71 and also received one or more for the same drug class in 1973-74.

Before these tables are discussed individually, mention must be made of the mixed drugs or compounds containing psychotherapeutic agents. These drugs, in 1970-71, comprised over 60% of all prescriptions dispensed by this insuring agency in contrast to the 18% of all prescriptions made up of "pure" psychotropic substances. The mixed or "hidden" psychotropics have probably increased in use since 1970-71.

As the indications for the use of these drugs had expanded to include all varieties of somatic disorders and their emotional sequellae, so have the sales of "hidden" psychotropics increased. For example, in 1973 there were as many prescriptions for Stelabid, a mixed psychotropic, as for Stelazine, the pure tranquillizer (29). Stelabid, however, is termed an antispasmodic drug and is never identified as a psychotropic, consequently deflating the actual proportion consumed.

It is impossible to know how the inclusion of the "hidden" psychotropics would affect these tables but we can assume the proportion of users would increase by a third in 1970-71 and probably by more than that amount in 1973-74, thus accounting for some of the decline in the proportion receiving prescriptions in 1973-74, as shown in the following tables.

Table V is the summary table for all psychotropic drugs--the major and minor tranquillizers, sedatives, antidepressants, and anorexiants. One finds a consistently higher proportion of users among the women than among the men at each time period (18% of the men had received one or more prescriptions in 1970-71 compared to almost 31% of the women in that year, while in 1973-74 the proportions were 14.5% and 24%, respectively).

Additionally, more women than men in each time period received a large number of prescriptions. Five percent of the women in 1970-71 and 3.3% in 1973-74 received 10 or more prescriptions during the year (these can be assumed to

TABLE V *Ontario Insurance Agency Data—Proportion of Persons Receiving Prescriptions for Psychotherapeutic Drugs in 1970-1971, and 1973-1974*

No. of Prescriptions	Males		Females	
	1970-1971	1973-1974	1970-1971	1973-1974
Zero	82.0	85.5	69.2	76.1
One	7.9	6.1	10.3	8.3
Two-Four	5.7	4.8	10.2	8.0
Five-Nine	2.6	2.1	5.3	4.3
Ten Plus	1.8	1.5	5.0	3.3
Total (Total N)	100.0 (15,775)	100.0 (15,775)	100.0 (14,578)	100.0 (14,578)
% Receiving one or more prescriptions	18.0	14.5	30.8	23.9
% Receiving a prescription in 70/71 who also received one or more in 73/74		6.9		15.1

TABLE VI *Ontario Insurance Agency Data — Proportion of Persons Receiving Prescriptions for Minor Tranquillizers in 1970-1971, and 1973-1974*

No. of Prescriptions	Males		Females	
	1970-1971	1973-1974	1970-1971	1973-1974
Zero	91.4	91.0	84.3	84.7
One	4.3	4.5	7.1	6.3
Two-Four	2.7	2.8	5.2	5.5
Five-Nine	1.1	1.2	2.1	2.4
Ten Plus	0.5	0.5	1.3	1.1
Total (Total N)	100.0 (15,775)	100.0 (15,775)	100.0 (14,578)	100.0 (14,578)
% Receiving one or more prescriptions	8.6	9.0	15.7	15.3
% Receiving a prescription in 70/71 who also received one or more in 73/74	2.9		6.7	

TABLE VII *Ontario Insurance Agency Data. Proportion of Persons Receiving Prescriptions for Sedatives in 1970-1971 and 1973-1974*

No. of Prescriptions	Males		Females	
	1970-1971	1973-1974	1970-1971	1973-1974
Zero	93.8	95.1	90.0	92.9
One	3.2	2.4	4.8	3.3
Two-Four	1.6	1.4	2.7	1.8
Five-Nine	0.8	0.6	1.3	1.1
Ten Plus	0.6	0.5	1.2	0.9
Total (Total N)	100.0 (15,775)	100.0 (15,775)	100.0 (14,578)	100.0 (14,578)
% Receiving one or more prescriptions	6.2	4.9	10.0	7.1
% Receiving a prescription in 70/71 who also received one or more in 73/74	2.0		3.3	

TABLE VIII *Ontario Insurance Agency Data. Proportion of Persons Receiving Prescriptions for Anti-Depressants in 1970-1971, and 1973-1974*

No. of Prescriptions	Males		Females	
	1970-1971	1973-1974	1970-1971	1973-1974
Zero	97.3	97.8	93.7	95.1
One	1.4	1.1	3.0	2.3
Two-Four	0.8	0.7	1.8	1.4
Five-Nine	0.3	0.3	0.9	0.8
Ten Plus	0.2	0.1	0.6	0.4
Total (Total N)	100.0 (15,775)	100.0 (15,775)	100.0 (14,578)	100.0 (14,578)
% Receiving one or more prescriptions	2.7	2.2	6.3	4.9
% Receiving a prescription in 70/71 who also received one or more in 73/74	0.4		1.5	

be steady users), in contrast to fewer than 20% of the men in each year. The last, and perhaps most important information provided by this table is the proportion of the population receiving a prescription for a psychotropic drug in the first year who also received one or more prescriptions three years later. Seven percent of the males and 15% of the females fell into this category, suggesting that, once having had a prescription for a psychotropic, one is more likely than not to receive additional prescriptions. Again, note the 2:1 ratio of females to males represented here.

Table VI, dealing with the minor tranquillizers (largely diazepam and chlordiazepoxide or Valium and Librium), demonstrates very similar patterns to the summary table, with close to the same 2:1 ratio prevailing. Both years find 9% of the men and more than 15% of the women receiving a tranquillizer prescription while, again, more women than men receive multiple prescriptions. Just under 3% of the men and almost 7% of the women received prescriptions for these drugs in both years.

The most striking finding in Table VII is the actual decrease in the proportion of the population receiving sedative drugs. (Included in the classification of sedative drugs are the barbiturates and the non-barbiturates, sedative and hypnotic drugs; minor tranquillizers used for sedation or as a hypnotic are still classified as minor tranquillizers.) The standard ratio of 2:1 is somwhat diminished in the case of the sedatives which can probably be accounted for by the fact that sedative drugs are more likely to be dispensed to older populations; as we have seen older persons look more alike in their utilization of medical services.

The last table gives the same figures for antidepressant drugs. The excess of women over men presenting symptoms of depression is reflected in the high proportion of females to males receiving these drugs. As with the sedatives, there seems to have been a slight decline in the prescribing of these drugs over the three years, although it must be noted that more than 2% of the men and almost 5% of the women received one or more antidepressant prescriptions in 1973-74.

Although there is only a limited number of studies dealing directly with these variables, there are some data on

employment and marital status in relation to illness and psychotropic drug use. A careful review of these factors may help in a further understanding of the 2:1 ratio.

United States admissions to all types of psychiatric facilities (30) indicated females "had relatively higher proportions of admissions in the married and widowed categories than did males, whereas males had a proportionately greater number of admissions classified as never married". (p. 4) These relationships tended to hold among all age groups except the youngest and oldest.

Wadsworth et al. (6), in their London population, found that of those complaining of headache and fatigue a significantly higher proportion of housewives than employed persons sought help for these problems with a physician (p. 55). In addition to housewives, others more likely to utilize physicians' services were the retired and the unemployed.

The one study dealing directly with the issue of marital status of women, and psychotropic drug use, was conducted in 1958 and again in 1971 in New Zealand (31). The women in this study are divided into those who had never married and those who were married, widowed, divorced, or separated all combined.

Unfortunately, data were not controlled by age so some part of the relationships shown may be age-related. However, most striking in this study was the similarity in the consumption patterns of single women and all adult men. Married women in 1958 received twice as many prescriptions for psychotropics as either of the other groups. By 1971 the gap had widened: On an average day in 1971, 3.7% of the population were taking a tranquillizer, but 8.3% of married women were taking them as compared to about 3.4% of adult males or unmarried adult women.

The figures for those using hypnotics, tranquillizers, or both, were equally startling: 11.6% of married women, 4.5% of never-married women, and 4.4% of adult males.

Chambers et al.'s US national study (26) leads them to conclude that regular users of prescription psychotropic drugs are white females beyond 35 years of age enjoying at least a middle class socio-economic status; these users are normally found to be housewives or not engaged in the labor force. (p. 50)

Nathanson (12), in her review *Illness and the Feminine Role* writes: "Employment has, perhaps, the most clearly positive effects on women's health of any variable investigated to date." (p. 60) She cites studies showing that working women present fewer symptoms than non-working women of the same age and report fewer disability days and less anxiety. Chambers et al.'s (26) data on drug use substantiate these findings.

Summary and Conclusions

This paper has attempted an examination of some of the socio-cultural factors affecting the rate at which men and women receive prescriptions for psychotropic drugs. Perhaps more than anything else, it has demonstrated the need to view the problem of use of these drugs in a broader perspective than that of the individual and his/her psychic difficulties. A socio-cultural approach to this problem rejects the concept of the immutability of the 2:1 female to male ratio of use, unless one also accepts the immutability of the social structure of society.

We have touched on a number of issues regarding health, and perceptions of health, which appear germane to our topic. Women clearly do report more feelings of discomfort, more symptoms, than do men. They also engage in more active intervention in helping alleviate these symptoms, whether that intervention takes the form of attending a physician or of self-medication.

Beyond the sex differences demonstrated, we have seen that certain life situations seem to produce more morbidity and help-seeking behavior. (Whether these statuses protect against the development of symptoms or only the translation of these symptoms into an illness model is not fully clear. What is clear is that health and illness can be seen as a continuum and that few people anywhere would ever fit the "health" end when one considers the World Health Organization definition of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.")

The extant data on marital and employment status bring into question the commonly held view that "stresses" arising

from conflicting social roles (e.g. wife, mother, worker) and pressures from multiple roles are creating the problems of women leading to higher morbidity and consequent psychotropic drug use. The empirical evidence to date suggests contemporary women filling numerous roles have somewhat lower morbidity, fewer days sick, and take fewer tranquillizers and sleeping medications, than their sisters filling the "traditional" female roles.

We have also shown some of the influences at work on the contemporary physician and the ways these can affect his perceptions of men and women patients. Too little attention has been paid in this section to the influences of the pharmaceutical industry on the medical profession. However, that would have required another complete paper.

Critical to our understanding of the sex differences in drug use today is an understanding of the expansion of the medical model to encompass increasing aspects of our lives. This, along with the development of psychotropics, has had a profound effect on the medical profession, not least of which has been the sanctioning, within a medical model, of a variety of stereotypic views of women as well as the provision of the tools with which to "treat" the "problems" seen.

The importance of understanding this spill-over of social problems to a medical model is discussed by Zola (32) when he describes the "increasing use of the metaphor of health and illness as an explanatory variable if not the explanation itself of a host of social problems". His concern is "what happens when a problem and its bearers become tainted with the label illness". (p. 85) He further describes the medical model as producing "a 'go-no-further effect' and one largely due to that aspect of the medical model which locates the source of trouble, as well as the treatment, primarily in individuals. While this may have a pragmatic basis in the handling of a specific organic ailment when a social problem is located primarily in the individual or his immediate circle, it has the additional function of blinding us to larger and discomforting truths." (p. 85)

An immediate conclusion that one can reach regarding this expansion of the medical model is that, not only do the consumers of services require education on this issue, but

the providers of services require as much, if not more, education.

Medical students, and others providing services, require a greater knowledge of the behavioral sciences. This could serve a dual function: a) They would learn to recognize social stereotypes and the role of their own values as they effect judgements of problems and treatment modalities, and b) They would grow to understand the limitations of "traditional" medicine and the value of other, alternate services.

Our examination of the existing Canadian data on drug use patterns has demonstrated changes in the composition of what we call psychotropics. For example, the barbiturate drugs have diminished in use while the minor tranquillizers have taken up the slack.

Although there is a great deal of interchangeability between these substances, the change in choice of drug will no doubt have some influence on the age-sex distribution of users.

The longitudinal data from southern Ontario suggest clearly that consumption of psychotropics is not a random phenomenon. The data show that half or more of those individuals receiving a prescription for a psychotropic drug in one year, also receive a prescription for a psychotropic three years later. The data presented, however, were not based on a random sample of the population and, although a great deal can be learned from such non-random samples, our knowledge of drug use is hindered until a national system of prescription data collection comes into existence.

The distribution patterns of these drugs make it clear that additional governmental controls are needed to prevent the expansion of sex-linked advertising and non-medical indications for use.

In this respect, it would be valuable, as a start, to demand the deletion of all drawings or photographs of men or women from advertisements by the pharmaceutical industry.

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THE CONSULTATION

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Purpose

The purpose was to contribute to the understanding of women and their use of alcohol and other legal drugs by attempting to meet the following objectives:

1. Collecting facts, opinions, and experiences.
2. Raising and responding to significant questions and issues.
3. Making recommendations to appropriate bodies.

Method

Achievement of the objectives in the time allowed was dependent on 1) selection of participants; 2) identification of specific issues; and 3) development of a goal-oriented format.

Participants were selected with the assistance of Addiction Research Foundation centres throughout the province. Each centre submitted the names of three people with practical and/or academic involvement in the subject area. From a card index of these names, invitations were sent to 27 women representing Ontario in terms of geography and expertise. (1)

The issues were identified by participants prior to the Consultation. Each participant was asked to raise three concerns based on personal, professional, and community experience. Concerns relating to prevention and treatment were most common. The issues on which work was to focus were as follows:

1) Chemical Solutions to Social Problems--the role of health care services in the prevention of chemical dependency among women;

2) Service Responses to Special Needs--understanding

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(1) Appendix A.

and reaching women with chemical dependency problems in order to develop resources which relate to their needs.

The format involved dividing participants into four groups, with two groups working separately on each issue. Guidelines for the groups specified three phases of the work.

Phase I:
a) Assessment of the present situation.
b) Identification of changes needed.

Phase II:
a) Identification of barriers to change.
b) Problem-solving--overcoming barriers to change.

Phase III:
a) Formulation of recommendations.
b) Allocation of responsibility for distribution and follow-up on recommendations.

At the end of each phase, plenary sessions enabled groups to exchange information.

Proceedings

A. *The Contract*

At the outset, participants agreed to the agenda (2) and expressed commitment to the issues and process. They also endorsed the following statement submitted by a participant:

> "We believe the issue of women's problems with legal drug use must be analyzed by taking into account the role of women in society and the way in which women are perceived."

B. *Group Discussion*

Discussions focused on the agreed issues but were stimulating and wide-ranging, as was the intention of the organizers.

While the resulting recommendations reflect the essence of the discussions, they are, of necessity, brief. Therefore, the following summaries, although they cannot adequately capture the richness of debate, are provided in an attempt to give readers some idea of the process which led to the recommendations.

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(2) Appendix B.

a) Chemical Solutions to Social Problems

The role of the health care services in furthering chemical dependence among women, and the part women play in this as consumers of those services, was examined. It was felt dependence is fostered, explicitly and implicitly, in most transactions between women as consumers and those who deliver service. That this is so is a product of the social structures which inform and maintain such behaviors and attitudes. These structures are governmental, educational, professional, and familial.

The medical model was seen as the dominant influence in most health care services, and special reference was made to physicians and nurses.

The relationship between physicians and their female patients was analyzed as one between the strong and the weak. Physicians, 92% of whom are men, reflect a socialization process in which male children are raised to feel physically and emotionally superior to female children--a process perpetuated throughout their education. They frequently diagnose women as emotionally sick when their symptoms are social in origin thus making "medical" problems of social problems and allowing for the prescribing of psychotropics as the solution. Because their real problems are not addressed, women make repeated visits and receive additional prescriptions and are thereby manoeuvred into both personal and chemical dependence.

Problems with alcohol are also avoided by doctors who, yet again, tend to see "emotional" illness. This reinforces the notion that alcoholism in women carries a moral stigma. When alcoholism *is* diagnosed, intervention frequently takes the form of tranquillizers or inappropriate referrals, which may be seen as a form of rejection.

Nurses also play a significant role in the fostering of dependence. They are poor role models for women patients, tend to play subservient roles on health teams, and have no representation on medical advisory committees or boards which influence health care delivery.

In relation to alcoholic patients, it has been observed that they tend to be nurturing and supportive with men but judging and hostile with women. Better prepared for

counselling than most physicians, and in a good position to practice preventive health care, nurses, nevertheless, seem to feel their chief obligation is to physicians and the prevailing system rather than to their patients and the public. An exception might be the public health nurses in northern federal jurisdictions who tend to play a more independent role.

For their part, women are largely accepting of the dependent role as consumers of health services. This is consistent with their social conditioning and is reinforced by the media.

Women tend to be "other-directed", that is, to take the lead from such "others" as husbands, brother, employers, etc. Because they have little economic, political, or social power, they are often forced into this situation. Thus, it has reached the point where it seems natural for women to defer to authority and believe their satisfactions come from serving others. Any consequent sign of physical and psychological stress is taken by others and even by themselves as a sign of personal failure. They therefore expect physicians to solve what are essentially problems of living. Products of their own consumer culture, they readily accept prescriptions.

Compounding this is the fact women are isolated from each other, which increases their sense of powerlessness. What women need and want was phrased as "respect back, more greenback, you off my back"!

The route to change was considered to be through specific improvements in a variety of structures. The educational system in its training of health and social care workers is lacking in a number of areas. While medical school admission policies may not be directed *against* women, women tend to be deterred indirectly—by lack of encouragement by society, families, and their own education. Once in medical schools, internships, or residencies, there are few, if any, resources to assist female physicians to meet family obligations.

Medical training pays little heed to the area of alcohol and drugs, particularly as these substances relate to women. Options to the medical model which might help women with problems they bring to health care services are either nonexistent or not discussed. Physicians, in particular, make

rare use of community resources.

The financing of health care services with its emphasis on fee for service, and lack of global budgeting, is conducive to fragmentation of service and professional control, with little accountability to the consumer. Similarly, the impact of the pharmaceutical companies is great in medical education (bursaries and materials) and in the funding of research projects--without public accountability.

b) Service Responses to Special Needs

Understanding women with chemical dependency problems was considered essential if women are to be reached and resources designed which relate to their needs. At present, this understanding is handicapped by a lack of study generally and in Ontario specifically. However, it is clear women, as a group, are subjected to sex stereotyping. Such stereotyping permeates both programs and advertisements in the media, reinforcing public attitudes. This is heightened where health and social problems are concerned and develops into a stigma with regard to women and addictions. Particular reference was made to the manner in which women are portrayed in advertisements for psychotropic drugs in medical journals and the impact this has on professional attitudes.

Given this social climate, the "hidden" woman alcoholic is an understandable phenomena. Reaching these women must be achieved in thoughtful and inventive ways with the goal being to eliminate the current view of women alcoholics. Public education programs, industrial programs, and training for health and social care workers in the identification and treatment of such women, were suggested.

Even for the woman who does seek treatment, there are few resources in Ontario. Of the 265 beds for detoxication across the province, 25 are for women. The difficulty is that the number of beds is determined by legal rather than social criteria and very few women are arrested as public inebriates. The recovery home situation is similar.

Even less is known about available services for chemically dependent women in hospitals, social agencies, etc. It would seem, however, that while women are eligible to enter the available services, none is designed exclusively for

women. In designing programs for women, consideration should be given to the following:

- behavioral descriptions to discourage easy diagnosis of "emotional illness";
- child care services to equalize access;
- attitudes of staff;
- optional resources to the medical model, such as self-help and feminist counselling.

The question of special resources for women is one which lacks documentation. Without evidence of incidence, characteristics, etc., it is doubtful whether resources will be allocated. The fact there are few women in decision-making positions in health and social care systems may account for the lack of research and service development. Powerlessness within the hierarchies is something women professionals share with chemically-dependent women: It strengthens the importance of collectivity and mutual aid in developing a treatment strategy or as a means of pressuring for change.

Recommendations

As the final phase of the work, each group submitted recommendations. Prior to the voting, during the last plenary session, two statements were endorsed by all participants:

> *It is the premise of this Consultation that many problems currently presented by women to health care professionals as individual problems are, in fact, social problems requiring social rather than chemical solutions.*
>
> *We believe all attempts at prevention or treatment will be largely inadequate if the social structure, which limits women's full participation in this society, is not changed.*

Twelve recommendations, to be directed to various individuals and organizations, were passed:

1. Education of Health Workers

   We recommend:

   (a) that expansion of teaching behavioral sciences include knowledge of particular problems of women with alcohol and drug abuse problems. This should include the recognition of non-medical (therefore non-chemical) solutions to social problems;

(b) that within medical and nursing schools there be at least one course on awareness and use of community resources as optional solutions to social problems, e.g. child and family services, detox centres, houses for women in crisis, self-help groups;

(c) that native speaking social counsellors, public health nurses, and those in the health services, have their roles expanded to include alcohol and drug education;

(d) that in view of increased consumption of prescription drugs by the total society and particularly women, a greater emphasis be placed on the teaching of clinical pharmacology in medical and nursing schools.

Directed to:
- Medical schools
- Federal and provincial ministries of health
- Ontario Medical Association and Canadian Medical Association
- Dr. A.E. Morrison, deputy minister, Health Protection Branch
- Dr. Alan Dyer, director of Parcost, Ontario Ministry of Health
- Howard Rodine, regional director, Indian Affairs
- Ministry of Education
- Nursing schools.

2. Equalizing Opportunities

We recommend:

(a) that a greater effort be made in primary and secondary schools to create a climate which encourages women to choose medicine as a career;

(b) that all medical schools increase the proportion of incoming female students, within a five-year period, to approximate the provincial population distribution;

(c) that specific attention should be paid to the readjustment of intern and residency programs to allow medical students to fulfil their family obligations.

Directed to:
- Medical schools
- Federal and provincial ministries of health
- Ontario Medical Association and Canadian Medical Association
- Dr. A.E. Morrison, deputy minister, Health Protection Branch
- Dr. Alan Dyer, director of Parcost, Ontario Ministry of Health
- Ontario Ministry of Education.

3. Continuing Education of Health Care Workers

We recommend that post-graduate continuing education alert physicians and other health care workers to recognize the hidden female alcoholic and to understand the dangers of prescribing psychoactive drugs to women, particularly those who are already dependent on alcohol and/or other drugs, and to consider alternate solutions such as feminist counselling, self-help groups, etc.

Directed to:
- College of Family Physicians
- Ministry of Education
- Medical and nursing schools
- Federal and provincial ministries of health
- Ontario Medical Association and Canadian Medical Association
- Dr. A.E. Morrison, deputy minister, Health Protection Branch
- Dr. Alan Dyer, director of Parcost, Ontario Ministry of Health.

4. Research Monitoring

We recommend that the provincial ministries of education and health establish a structure to include lay people and health care workers to monitor and make

public the impact of funding by the pharmaceutical industry on research within the educational setting.

Directed to:
- Ministry of Education
- Medical and nursing schools
- Federal and provincial ministries of health
- Ontario Medical Association and Canadian Medical Association
- Dr. A.E. Morrison, deputy minister, Health Protection Branch
- Dr. Alan Dyer, director of Parcost, Ontario Ministry of Health.

5. Consumer Education and Control of Advertising

We recommend:

(a) that the Ontario Ministry of Health provide more information to the consumer concerning adverse reactions, drug interactions, and cost of drugs;

(b) that a health hazard warning be included in the packaging of psychotropic drugs with specific reference to the dangers of combining them with alcohol and/or drugs and to the development of dependence through their misuse;

(c) that all advertising of prescription drugs be replaced by presentation of factual information without photos, drawings, pictures; that full disclosure of all known adverse reactions and potential drug interactions be included; and that if the drug industry does not respond favorably within a time limit of not more than one year, the government should pass legislation to bring this about;

(d) that the federal government legislate that trade names be abolished and that prescriptions be sold by generic name, followed by the name of the manufacturing company, to avoid confusion and abuse;

(e) that liquor and cigarette advertising be banned from all media.

Directed to:
- Ministries of health
- Ontario Medical Association and Canadian Medical Association
- Dr. A.E. Morrison, deputy minister, Health Protection Branch
- Dr. Alan Dyer, director of Parcost, Ontario Ministry of Health
- Ontario Status of Women Council
- Pharmaceutical Manufacturer's Association of Canada
- Solicitor General.

6. Reorganization of Health Care

We recommend that the province take the initiative and proceed at a faster pace with an increased number of health units working under global budgets that allow health care workers to meet the needs of chemically dependent people.

Directed to
- Federal and provincial ministries of of health
- Ontario Medical Association, Canadian Medical Association, and Ontario Health Insurance Plan.

7. Public Accountability

We recommend that the College of Physicians and Surgeons make more of their proceedings available to the public for assessment.

Directed to:
- The Ontario College of Physicians and Surgeons
- Ontario Medical Association and Canadian Medical Association.

8. Prescription Registry

We recommend that a federal computerized registry of all prescriptions dispensed in Canada be established and this system be monitored with appropriate consumer safeguards.

Directed to:
- Medical schools

- Federal and provincial ministries of health
- Ontario Medical Association and Canadian Medical Association
- Dr. A.E. Morrison, deputy minister, Health Protection Branch
- Dr. Alan Dyer, director of Parcost, Ontario Ministry of Health.

9. Women, Alcohol, and Industry

We recommend:

(a) that literature and films used in industrial programs recognize the alcohol-related problems of women employees;

(b) as a preventive measure, the formation of women's groups within the work setting so that women may define and discuss their problems and receive mutual support.

Directed to:
- Addiction Research Foundation of Ontario (Industrial Task Group)
- Public Service Alliance
- Canadian Labor Congress
- Canadian Union of Public Employees.

10. Drugs as Social Control

We recommend that the responsible federal and provincial ministries recognize the over-prescription of psychotropic drugs as a means of social control in many total care institutions such as psychiatric hospitals, geriatric centres, nursing homes, prisons, and youth training schools.

Directed to:
- Federal and provincial ministries of health
- Ministry of Corrections
- Ministry of Social and Community Services
- Caucus of Parties in Legislature.

11. Research and Evaluation

We recommend:

(a) recognizing the paucity of information on women and alcohol-related problems, that immediate emphasis be placed on epidemiological research on this topic;

(b) that present treatment facilities for alcohol-related problems be evaluated to establish the degree to which they are meeting the needs of women.

Directed to:
- Addiction Research Foundation of Ontario
- Federal and provincial ministries of health.

12. Affirmative Action

We recommend that institutions dealing with women with alcohol- and drug-related problems establish affirmative action committees to set quotas for women in management within a specific period of time.

Directed to:
- Addiction Research Foundation of Ontario
- Non-Medical Use of Drugs Directorate
- Donwood Foundation
- Other relevant agencies.

Follow-up

A group of 13 women from the Consultation agreed to distribute the recommendations, with suitable documentation, to the appropriate bodies, and to ensure follow-up. This group has become the Women's Caucus on Alcohol and Legal Drugs (Ontario).

APPENDIX A: PARTICIPANTS

Doreen Birchmore Toronto	Social worker; head, Donwood Institute day clinic, a co-ed residential treatment program for alcoholics.
Penny Bradley Kenora	Health worker, Grand Council Treaty No. 3; Social Planning Council; Kenora Native Women's Group.
Joy Caron Thunder Bay	Head nurse at psychiatric hospital treatment program for alcoholics.
Anne Cools Toronto	Director, Women in Transition, temporary residence for women and children.
Ruth Cooperstock Toronto	Sociologist--scientist, social studies department, Addiction Research Foundation of Ontario.
Monica Cullum Sudbury	CDO counsellor, Ministry of Community and Social Services, vocational rehabilitation; volunteer working directly with women serving jail sentences for alcoholism.
Maureen Duggan Ajax	Public health nurse, Durham Regional Health Unit; educational and preventive programs in a local high school.
Lynn Eakin Toronto	Social worker, Addiction Research Foundation of Ontario; direct service with addicted clients; education programs with high risk women's groups.
Nancy Huneault Toronto	Head nurse, Alcohol and Drug Treatment Unit, Royal Ottawa Hospital.

Winnie Fraser Toronto	Acting director, Addiction Research Foundation of Ontario detoxication unit. Now at alcoholism unit, Yellowknife, NWT.
Susan Gibson Toronto	Researcher, Ontario Status of Women Council.
Claire Hobbs Toronto	Recreation and craft specialist volunteer; community activist; recreation coordinator at Thistletown Community Services; Humber College Centre for Women.
Sadie Landreville Cornwall	Interested citizen; community needs for women alcoholics.
Helen Levine Ottawa	Social worker; feminist counsellor; lecturer at Carleton University school of social work.
Gail McCall London	Social worker; director of the women's branch of London Mission Services; director of the mission's Rothholme, a recovery house for female alcoholics.
Fran McCormick St. Catharines	Community activist; Addiction Research Foundation of Ontario, investigating the nature of the problem of women and chemicals.
Edna Mulligan North Bay	Senior public health nurse, Addiction Research Foundation of Ontario, direct treatment with female drug users.
Susan Ogurzsoff Kingston	Researcher, Queen's University: Research director Non-Medical Use of Drugs Directorate treatment development project.
Marguerite O'Rourke Hamilton	Co-director, Open Arms Haven for Women, a drop-in detox and temporary residence for women.

Martha Sanchez-Craig Toronto	Psychologist, Addiction Research Foundation of Ontario: Director--researcher, Spadina Halfway House project for women and men problem drinkers.
Sharon Somfay Kitchener	Psychologist; program assistant, Bon Accord Farm, Elora 1972-1973; co-author "Ascent from Skid Row".
Sandy Stienecker Toronto	Community organizer, YWCA.
Kathy Recker Belle River	Registered nurse; interested citizen, looking at the needs of women alcoholics in Windsor area.
Terry Shamess Sault Ste. Marie	Interested citizen; volunteer helping women with alcohol or drug problems.
Elaine Vayda Hamilton	Social worker; lecturer at McMaster University school of social work.
Sylvia vonHanna Toronto	Physician interested in the area of drugs and women.
Margery Pinney Toronto	Assistant to the director, Ontario Status of Women Council. (Now on executive staff of the New Democratic Party.)

Organizers and Group Leaders

Pat Badiet Ottawa	Social worker, Children's Aid Society.
Jessica Hill Toronto	Social worker, Non-Medical Use of Drugs Directorate.
Rita Lucht Ottawa	Social worker, Non-Medical Use of Drugs Directorate.
Lavada Pinder Ottawa	Social worker, director, Ottawa-Carleton programs, Addiction Research Foundation of Ontario.

Recorders

Benita Blustein Ottawa	Social worker; interested citizen.
Virginia Carver Ottawa	Psychologist, Drug and Alcohol Treatment Unit, Royal Ottawa Hospital.
Carol Ann Pease Ottawa	Social worker, Children's Aid Society.
Katherine Turner Ottawa	Sociology student, Carleton University.

Secretary

Rosina Tracey Ottawa	Addiction Research Foundation.

Press

Pat Bell Ottawa	Freelance writer.
Anne MacLennan Toronto	Associate editor, The Journal, Addiction Research Foundation of Ontario.

APPENDIX B: THE AGENDA

INTRODUCTION

In addition to naming the specific issues to discuss, we have also chosen some phrases and sentences from our talks which elaborate on these issues.

The Issues

1. *Chemical Solutions to Social Problems.* The role of health care services in the prevention of chemical dependency among women.

The Consumers

"What conditions drive women to drugs as a solution to their problems?"

"Does the traditional role of women in the nuclear family inevitably create unbearable stresses for women that can lead to increased alcohol and drug use?"

"Are women 'other-directed', always seeking help from doctors, social services, etc., instead of relying on their own resources?"

"Are there certain jobs in the work force which foster more drinking?"

"Let's not fall into the trap of over-simplifying and saying shifting social roles are the sole cause of increased consumption among women."

The Providers

"How do the attitudes of mental health professionals effect the treatment of women?"

"Doctors are not sensitive to the problems of women and would rather hand out Valium like candy."

"Alcoholic women are being treated with drugs."

"How can we break the back of the medical model as the framework in which we attempt to solve social problems with medical solutions?"

"In whose interest are the professionals really working?"

Solutions

"Let's educate both providers and consumers of services considering such items as sex stereotyping and advertising."

"Can we influence advertising at the level in which the victim is blamed?"

"The pharmaceutical industries play a role in making both providers and consumers of services accept substance solutions."

"Changing attitudes is a long, slow process and must be worked on through education and by social control methods such as governing distribution, price setting, etc."

2. *Service Responses to Special Needs.* Understanding and reaching women with chemical dependency problems in order to develop resources which relate to their needs.

Reaching Out

"How do we reach women of high socio-economic status who continually show up in court and are let off?"

"How do we motivate the unemployable woman?"

"How do we reach younger, even adolescent women?"

"Let's consider the work forces which include large numbers of women such as insurance companies and banks."

Special Needs

"How do we find out what women need?"

"What should a program for women include that's different from programs for men?"

"Do we need equality of services between men and women or a totally different kind of service for women given an historically subordinate role in society?"

"Nothing for native women."

"In Sioux St. Marie we have to travel 400 miles north to

Thunder Bay or 400 miles east to Toronto for women's detox."

New Approaches

"What are some options to the medical model?"

"Can a dose of feminism be incorporated within standard treatment procedures?"

"How do we get women to act collectively on their problems?"

"In what ways can research contribute to treatment?"

"Women and alcohol—there's a lack of knowledge!"

The Method

Each participant has been assigned to a group (Work Groups listed below) to study one issue intensively over the two-and-a-half days of the Consult. This study involves three phases:

Phase I
a) Assessment of the present situation.
b) Identification of changes needed.

Phase II
a) Identification of barriers to change.
b) Problem solving: Overcoming barriers to change.

Phase III
a) Formulation of recommendations.
b) Allocation of responsibilities for distribution and follow-up.

It is our hope that this structure and the limited number of issues will encourage a significant outcome. Plenaries are arranged at the end of each phase to share information and keep in touch with the work of other groups. Wednesday morning will be devoted to reviewing recommendations, setting priorities, and arranging for follow-up.

The Agenda

Sunday, September 28, 1975	
8:30 - 10:00 p.m.	Informal Reception
Monday, September 29, 1975	
9:00 - 9:30 a.m.	*Plenary Session* Welcome and overview of Consult, Lavada Pinder.
9:30 - 10:30 a.m.	*Workgroups* Beginning to focus on the issues and sharpen questions to be directed to the authors of the Consultation papers.
10:30 - 11:00 a.m.	Coffee
11:00 - 12:00 noon	Question period with the authors of the papers.
12:00 - 1:30 p.m.	Lunch
1:30 - 4:30 p.m.	*Workgroups* *Phase I* Assessment of present situation and identification of changes needed.
4:30 - 5:30 p.m.	*Plenary* Exchange of information from Phase I.
Tuesday, September 30, 1975	
9:00 - 12:00 noon	*Workgroups* *Phase II* Identification of and overcoming barriers to change.
12:00 - 1:00 p.m.	Lunch

1:00 - 2:00 p.m.	*Plenary* Exchange of information from Phase II.
2:00 - 5:00 p.m.	*Workgroups Phase III* Formulation of recommendations and discussion of follow-up process.
5:00 - 6:00 p.m.	*Plenary* Exchange of information from Phase III.

Wednesday, October 1, 1975

9:00 - 12:00 noon	*Plenary* Reviewing recommendations, setting priorities, arranging follow-up. Evaluation of Consultation.

Work Groups

Chemical Solutions to Social Problems

-A-

Group Leader: Jessica Hill

Recorder: Katherine Turner

Participants: Penny Bradley
Ruth Cooperstock
Nancy Farnworth
Claire Hobbs
Fran McCormick
Sharon Somfay

-B-

Group Leader: Rita Lucht

Recorder: Virginia Carver

Participants: Anne Cools
Maureen Duggan
Lynn Eakin
Sylvia vonHanna
Edna Mulligan
Elaine Vayda

Service Responses to Special Needs

-A-

Group Leader: Lavada Pinder

Recorder: Benita Blustein

Participants: Doreen Birchmore
Monica Cullum
Joy Caron
Winnie Fraser
Helen Levine
Marguerite O'Rourke
Terry Shamess

-B-

Group Leader: Pat Badiet

Recorders: Carol Ann Pease
Zoe Carmody

Participants: Sadie Landreville
Gail McCall
Susan Ogurzsoff
Kathy Recker
Martha Sanchez-Craig
Sandy Stienecker

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